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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-01 Access To Care

Effective Date: August 13, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
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George A. Lombardi, Director
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I. **Purpose:** This procedure has been developed to all offenders within a correctional center or institutional treatment center have access to care that meets their serious medical, dental, and mental health needs.

A. **AUTHORITY:** 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Access to Care:** A patient/offender can be seen by a clinician, be given a professional clinical judgment, and receive care that is ordered.

III. **PROCEDURES:**

A. Access to required care shall be available to all offenders without regard to custody status or housing restrictions.

1. Access shall be provided with consideration to security concerns of the institution and specific security requirements of the offender.

B. Barriers or disincentives shall not be instituted to discourage offenders from seeking necessary medical, dental or mental health services.

1. Examples of barriers or disincentives include but are not limited to:

a. Punishing offenders in the form of conduct violations for seeking care for their health needs.

b. Scheduling clinic times that are not reasonably related to the needs of the institution (i.e., sick call at 2:00 am);

c. Deliberately permitting unreasonable delays before offenders are seen by prescribing providers or outside consultants to obtain necessary diagnostic work or treatment for their serious health needs; and

d. Interfering with prompt transmittal to health care staff of an offender's oral or written request for care;

C. Access to routine and/or non-urgent care shall be handled through a scheduling system.

D. Access to emergency or urgent care shall be available at all times.

IV. ATTACHMENTS

None

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003. P-A-01, Access to Care - *essential.*
B. IS11-7 Emergency Plan
C. IS11-29 Diagnostic Services
D. IS11-30 Hospital and Specialized Ambulatory Care
E. IS11-37.1 Daily Handling of Non-Emergency Medical Requests
F. IS11-38 Sick Call
G. IS11-39 Health Evaluation of Offenders in Disciplinary Segregation
H. IS11-41 Emergency Services
I. IS11-41.1 Self Declared Emergencies
J. IS11-45 Health Evaluation of Offenders in Administrative Segregation and Protective Custody

VI. HISTORY:

This procedure was originally covered by IS11-32.1 Access to Healthcare Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date: August 13, 2004

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-08 Communication on Special Needs Patients

Effective Date: **August 13, 2004**

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I. **Purpose:** This procedure provides guidelines for communication between the facility administration, health services staff, and treating clinicians regarding offenders' significant health needs that must be considered in classification decisions in order to preserve the health and safety of that offender, other offenders, or staff.

A. **AUTHORITY:** 217.175, 217.320 RSMo, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institutions or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Chronic Illnesses** requiring care and treatment over a long period of time and are usually not cured. The goal is to restore and maintain a person's activities of daily living to the extent possible. Examples of chronic illnesses include asthma, heart disease, diabetes, and hypertension.

B. **Developmentally disabled** offenders may need habilitation planning, assistance accepting the limitations of their conditions, and special attention to their physical safety in the correctional environment.

C. **Frail or elderly** offenders include those who suffer from conditions that impair their ability to function to the extent that they require assistance in activities of daily living (e.g., dress, feed, transfer, and toilet).

D. **Initial Classification Analysis (ICA):** The first classification instrument completed by certified classification users at the diagnostic center on all offenders committed to the custody of the department for purposes of initial assignment to an institution.

E. **Reclassification Analysis (RCA):** Instrument designed to analyze and offender's present custody status, completed at regular intervals, or as needed, by certified institutional staff.

F. **Physical disabilities** can refer to mobility impairments (e.g., amputation, paraplegia) or to other disabilities that limit a person's daily functioning (e.g., visual impairments, hearing impairments, and speech impairments).

G. **Pregnant** offenders, refer to IS11-55 Perinatal Care and IS11-58 Pregnancy Counseling.

H. **Serious communicable diseases** include those that are transmitted sexually, through the respiratory system, or by infected blood (e.g., syphilis, gonorrhea, chlamydia, HIV, tuberculosis, hepatitis).

I. **Serious mental health needs** include people with serious mental health needs, basic psychotic disorders, or mood disorders (e.g., manic-depressives); self-mutilators; the aggressive mentally ill; and suicidal offenders.

J. **Terminally ill** offenders include those with a life expectancy of 6-months or less due to illness. They may require special health services to provide comfort, relief from pain, and special counseling and support in anticipation of death.

III. PROCEDURES:

A. Offenders transferring into the facility should be assessed by health care staff as noted in IS11-33 Transfer Screening, and the medical record should be reviewed for special needs that may affect housing, programs, and work assignments such as:

1. chronic illnesses,
2. serious communicable diseases,
3. physical disabilities,
4. pregnant offenders,
5. frail or elderly,
6. terminally ill offenders,
7. serious mental health, or
8. developmentally disabled.

B. Medical and mental health recommendations for housing, program, and work participation should be made by the practitioner and communicated in writing to the classification staff via Initial Classification Analysis Medical Need form (Attachment A), or Reclassification Analysis Medical Needs form,(Attachment B).

C. Health care staff should advise classification staff of any medical problems, which could be escalated due to restrictive housing related to disciplinary actions.

1. Any verbal notification should be followed with a memorandum.

D. Mental health staff should advise classification staff of any mental health problems, which could be escalated due to restrictive housing related to disciplinary actions.

1. Any verbal notification should be followed with a memorandum.

IV. ATTACHMENTS

A. 931-0354 Initial Classification Analysis (ICA) Medical Needs (M)
B. 931-0358 Reclassification Analysis (RCA) Medical Needs (M)

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-A-08 Communication on Special Needs Patients -*essential*, P-G-01 Special Needs Treatment Plans - *essential*, P-G-02 Management of Chronic Disease - *important*.
B. IS11-8.1 Medical Permits/Clinical Health Permits
C. IS11-14.2 Tuberculosis Control
D. IS11-14.3 Communicable Disease Isolation
E. IS11-14.4 HIV Offenders
F. IS11-33 Transfer Screening
G. IS11-44.1 Medical Continuity of Care
H. IS11-51 Special Needs Treatment Plans
I. IS11-52 Infirmary/Transitional Care Service
J. IS11-55 Perinatal Care
K. IS11-58 Pregnancy Counseling
L. IS11-59 Orthoses, Prosthesis, and Other Aids to Impairment
M. IS11-73 Advance Directives
N. IS11-74 Do Not Resuscitate

VI. HISTORY:

This procedure was originally covered by IS11-7.1 Communication on Special Needs Patients Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date: August 13, 2004

Attachment A

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

INITIAL CLASSIFICATION ANALYSIS (ICA) – MEDICAL (M) NEEDS

OFFENDER NAME	DOC NUMBER	DATE OF BIRTH

INSTRUCTIONS: "X" APPROPRIATE LEVEL AND ENTER THE M-SCORE

☐ **M-5 CHRONIC CARE/SKILLED CARE NEEDED**

- 24 hour Transitional Care Unit (TCU) Assignment - This may be a temporary or permanent assignment.
- Schedule II narcotic necessary
- Unstable and/or non-compliant with treatment, diabetes, grand mal seizure, coronary artery disease, chronic obstructive pulmonary disease or other chronic problem
- Terminal illness

☐ **M-4 LIMITED TRANSITIONAL CARE UNIT (TCU) SUPERVISION REQUIRED**

- 24 hour nursing staff availability
- 24 hour Transitional Care Unit (TCU) availability
- Schedule II narcotics necessary
- Grand mal seizure free for less than 1 year
- Moderate COPD, CAD, diabetes, asthma or other chronic problem

☐ **M-3 CLINICAL SUPERVISION REQUIRED**

- 24 hour nursing staff availability
- No Transitional Care Unit (TCU) but observation is available
- Grand mal seizure free for 1 year
- Moderate COPD, CAD, diabetes, asthma or other chronic problems for 1 year
- Schedule III medications necessary

☐ **M-2 ROUTINE SICK CALL**

- 16 hour nursing staff availability
- Grand mal seizure free for greater than 1 year
- Stable COPD, CAD, diabetes, asthma or other chronic problem for 1 year
- On no controlled medications (Exception: medications for treatment of seizure disorder)
- No expected date of confinement/delivery date (EDC) within 5 months of arrival to the Missouri Department of Corrections

☐ **M-1 NONE**

- No treatment needs
- No physical ailments or medical difficulties
- Not enrolled in a chronic care clinic

RESTRICTIONS/SPECIAL NEEDS

☐ **(R) RESTRICTED:** Physical or transfer restrictions apply. Investigate before transfer. (Please "X" ALL restrictions that apply.)

AMBULATORY

☐ Unable to walk up or down stairs
☐ Unable to walk more than _____ yards without assistance
☐ Unable to walk to meals or medical unit
☐ Wheelchair requirements

PERCEPTUAL

☐ Hearing impaired
☐ Visually impaired and requires ambulatory assistance

HEALTH RELATED

☐ High-risk pregnancy; ineligible for CRC
☐ Oxygenator or Continuous Positive Airway Passage (CPAP)
☐ Dialysis (must be placed @ MCC for males and WERDCC for females)
☐ Unable to participate in physical training
☐ Respiratory isolation (contact statewide medical director for medical clearance): CRCC, ERDCC, FRDC, JCCC, NECC, SCCC, SECC, TCC, WERDCC, WRDCC

☐ **(U) UNRESTRICTED:** No physical or transfer restrictions apply.

M - SCORE ►

COMMENTS (PLEASE NOTE ANY INFORMATION THAT WOULD ASSIST IN ASSIGNMENT; I.E., CURRENTLY RECEIVING TREATMENT FROM AN OUTSIDE SPECIALIST, ETC.)

SIGNATURE OF SCORER	TITLE OF SCORER	DATE

Attachment B

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

RECLASSIFICATION ANALYSIS (RCA) – MEDICAL (M) NEEDS

OFFENDER NAME	DOC NUMBER	DATE OF BIRTH

INSTRUCTIONS: "X" APPROPRIATE LEVEL AND ENTER THE M-SCORE.

☐ **M-5 CHRONIC CARE/SKILLED CARE NEEDED**

- 24 hour Transitional Care Unit (TCU) Assignment - This may be a temporary or permanent assignment.
- Schedule II narcotic necessary
- Unstable and/or non-compliant with treatment, diabetes, grand mal seizure, coronary artery disease, chronic obstructive pulmonary disease or other chronic problem
- Terminal illness

☐ **M-4 LIMITED TRANSITIONAL CARE UNIT (TCU) SUPERVISION REQUIRED**

- 24 hour nursing staff availability
- 24 hour Transitional Care Unit (TCU) availability
- Schedule II narcotics necessary
- Grand mal seizure free for less than 1 year
- Moderate COPD, CAD, diabetes, asthma or other chronic problem

☐ **M-3 CLINICAL SUPERVISION REQUIRED**

- 24 hour nursing staff availability
- No Transitional Care Unit (TCU) but observation is available
- Grand mal seizure free for 1 year
- Moderate COPD, CAD, diabetes, asthma or other chronic problems for 1 year
- Schedule III medications necessary

☐ **M-2 ROUTINE SICK CALL**

- 16 hour nursing staff availability
- Grand mal seizure free for greater than 1 year
- Stable COPD, CAD, diabetes, asthma or other chronic problem for 1 year
- On no controlled medications (Exception: medications for treatment of seizure disorder)
- No expected date of confinement/delivery date (EDC) within 5 months of arrival to the Missouri Department of Corrections

☐ **M-1 NONE**

- No treatment needs
- No physical ailments or medical difficulties
- Not enrolled in a chronic care clinic

RESTRICTIONS/SPECIAL NEEDS

☐ **(R) RESTRICTED:** Physical or transfer restrictions apply. Investigate before transfer. (Please "X" ALL restrictions that apply.)

AMBULATORY

☐ Unable to walk up or down stairs
☐ Unable to walk more than _____ yards without assistance
☐ Unable to walk to meals or medical unit
☐ Wheelchair requirements

PERCEPTUAL

☐ Hearing impaired
☐ Visually impaired and requires ambulatory assistance

HEALTH RELATED

☐ High-risk pregnancy; ineligible for CRC
☐ Oxygenator or Continuous Positive Airway Passage (CPAP)
☐ Dialysis (must be placed @ MCC for males and WERDCC for females)
☐ Unable to participate in physical training
☐ Respiratory isolation (contact statewide medical director for medical clearance): CRCC, ERDCC, FRDC, JCCC, NECC, SCCC, SECC, TCC, WERDCC, WRDCC

☐ **(U) UNRESTRICTED:** No physical or transfer restrictions apply

M - SCORE ►

COMMENTS (PLEASE NOTE ANY INFORMATION THAT WOULD ASSIST IN ASSIGNMENT; I.E., CURRENTLY RECEIVING TREATMENT FROM AN OUTSIDE SPECIALIST, ETC.)

SIGNATURE OF SCORER	TITLE OF SCORER	DATE

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-08.1 Clinical Health Permits Effective Date: June 3, 2005

Ralf Salke
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Elizabeth Conley, D.O.
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Steve Long, Acting Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

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I. **Purpose:** This procedure has been developed to provide uniform guidelines for issuing clinical health permits to offenders in any setting other than an infirmary.

A. **AUTHORITY:** 217.175, 217.320 RSMo, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Clinical Health Permits:** Any order given by a staff physician to possess an aid or item ordinarily prohibited, to engage in any activity ordinarily prohibited, or to not engage in any activity ordinarily required.

B. **MARS:** Computerized Medical Accountability Record System

III. **PROCEDURES:**

A. All physicians will be oriented by the regional medical director and psychiatrists by the director of psychiatry concerning the conditions and justifications for issuing clinical health permits prior to any such permits being issued.

1. The Lay-In/Medical/Duty Restrictions Form (Attachment A) will be completed.

2. Physicians, unless otherwise specified in this procedure, must authorize all clinical health permits.

3. Documentation of the medical/mental health need justifying the medical permit must be made in the offender's computerized medical record (MARS).

4. A copy of the clinical health permit will be sent to the offender's classification staff for placement in the classification file.

5. The physician will indicate any time limits for re-evaluation or expiration of the permit.

6. The maximum length of time any permit will be valid is 12 months. Following review by the physician, the permit may be extended.

7. The Health Services Administrator/designee will establish and monitor a system of file cards or computer database to track the issue date and expiration date of clinical health permits.

8. Upon transfer between institutions, all permits must be reviewed by the receiving physician and renewed, if needed.

   a. A copy of the clinical health permit will be sent to the offender's classification staff for placement in the classification file.

B. Guidelines for Clinical Health Permits:

1. **Extra Pillow:**

   a. May be written for patients who are postoperative from limb surgery, have chronic edema, orthopnea, or other major medical conditions.

2. **Cotton Blanket:**

   a. May be issued when an offender proves to the physician's satisfaction that she/he has a rash or has developed wheezing in response to regular wool blankets.

3. **Bed Board:**

   a. May only be issued in institutions without solid bed frames for offenders who have severe disabling back conditions and not for personal convenience.

4. **Walking Cane:**

   a. This permit should seldom be used. Under no circumstances are two canes to be issued to the same offender.

   b. Offenders with orthopedic conditions frequently benefit from the use of crutches instead of canes while the condition persists.

5. **Crutches:**

   a. Should be given to offenders, who are postoperative from surgical conditions of the lower extremities,

   b. have severe lower extremity sprains or fractures, or have an amputation.

c. Crutches may be approved by the health services administrator/designee until the next physician's sick call.

d. Crutches will be properly adjusted based upon height with proper use instructions provided by the issuing health care member.

6. **Low Bunk:**

a. Should be issued only to those offenders with seizure disorders or who, due to severe disability or postoperative status, are unable to climb onto the top bunk.

b. May be approved by the health services administrator/designee until the next physician's sick call.

7. **Orthopedic Shoes:**

a. Must be ordered by an orthopedic specialist or by prosthetics specialist.

b. The institutional physician may issue a medical permit for special shoes such as athletic shoes following surgery during recuperation, offenders with permanent surgical or congenital deformities or offenders with recent foot trauma.

8. **Lay-In with Bedrest:**

a. All permits are issued for lay-in with bedrest and prohibition of all sports/recreation activities.

b. Lay-ins may be given for a few days only to offenders who, while not in need of infirmary admission, are required to have bedrest due to trauma, exhaustion, flu-like illnesses, and similar conditions.

c. Physicians writing these passes should note, however, that offenders are not confined to their housing units.

d. Offenders are allowed to go to the dining room 3 times a day, to the chapel, to the law library, to the visiting room, and will be permitted to shower.

e. Offenders who must remain in bed at all times should not be placed on lay-in status, but should be admitted to an infirmary/transitional care unit.

f. This may be approved by the health services administrator/designee until the next physician's sick call.

9. **Photo Gray/Dark Prescription Glasses:**

a. To be issued by the optometrist or ophthalmologist for verifiable cases of medical necessity.

b. May be permitted to receive from home with approved justification from the department optometrist, ophthalmologist or medical section.

10. **Unable to lift over a specified amount of weight:**

    a. Issued by the physician upon finding medical evidence of back disease, atrophy of limbs, severe cardiovascular or metabolic conditions, or in some instances, for unoperated inguinal hernias.

    b. These permits must specify the weight limitations.

11. **Unable to work in dusty environment or in presence of chemical fumes:**

    a. Issued for severe respiratory conditions with established medical evidence.

    b. Generally, pulmonary function testing and specific allergy testing, when indicated, must be performed before the medical permit is issued.

12. **May use neck collar, brace, or similar devices:**

    a. Use for more than seven days must be approved by orthopedic specialist or regional medical director only.

13. **May wear a head covering:**

    a. Issued only for extreme medical conditions such as burns or documented solar keratosis, facial skin cancer, melanoma, and photosensitivity.

14. **May have ice pack:**

    a. After an accident necessitating an ice pack, one standard ice pack will be issued – this can be issued by the nurse.

    b. Ice packs will not be issued in gloves.

    c. Chemical packs will not be issued.

    d. This may be approved by the health services administrator/designee until the next physician's sick call.

15. **May wear braces or crutches while in segregation:**

    a. These items will be considered on a case-by-case basis by the health services administrator/designee and superintendent/designee, until reviewed by a physician.

    b. If not necessary for therapeutic reasons, the items may be stored and, if needed, utilized for movement purposes only.

16. **Items authorized to be sent from home:**

    a. The physician may authorize the following items to be sent from home: hearing aids, full or partial dentures, prosthetics, and orthopedic shoes or durable medical equipment, clear lensed prescription glasses or clear lensed prescription contacts. Glasses and contacts must be in accordance with IS22-1.1 Offender Authorized

Personal Property and received by the offender in accordance with IS22-1.2 Offender Property Control Procedures.

b. Such items must be due to genuine medical health need and documentation will be placed in the medical health record in MARS.

c. Written notification will be provided to appropriate institutional staff. Receipt will be handled per personal property procedures with the exception of glasses and contacts.

d. Upon receipt, the items will be examined by custody staff for security and medical staff for appropriateness except glasses and contacts and then only if the lens appear to be tinted, colored or transitional.

17. **Must change sheets/mattress/pillows – daily/weekly or any such combination:**

a. Shall not be issued unless for severe dermatological reasons, inability to control bladder function, etc.

1. The hygiene of mattresses, sheets, and pillows is not a medical matter.

18. **Cosmetic items such as skin creams, lotions, makeup, soap, shampoo, etc:**

a. Will be issued by prescription only where there is a documented, serious medical health need. Dry skin is not considered a serious medical health need.

C. The following clinical health permits are not to be issued except as noted:

1. **May shower at specific times:**

a. Shall not be issued.

b. The offender will be allowed showers in accordance with existing procedures relative to their housing assignments.

2. **May sleep with open window, closed window, near a fan, or any other building requirements:**

a. Shall not be issued.

b. All cases of offenders suffering from temperature related medical problems; asthmas, etc. should be referred to the regional medical director for a long-term solution to their problem.

3. **No pork, or give Instant Breakfast, extra food, vitamins, etc.:**

a. With the exception of special diets due to specific medical health needs (e.g., following extensive oral surgery, or severely debilitated individuals); this permit shall not be issued.

b. Offenders are provided a nutritionally adequate diet from which they may exclude foods they do not like; however, no special attempt will be made to increase the portions or types of food offered to an offender.

4. **Shower Shoes:**

   a. Shall not be issued.

   b. Shower shoes or flip-flops generally are used when taking showers.

   c. This type of shoe precludes the offender from going to a work assignment, as shower shoes are unsafe for work.

5. **Extra mattress or egg crate style mattress:**

   a. Shall not be issued except in Transitional Care Unit/Infirmary for documented serious medical/mental health needs.

IV. ATTACHMENTS

A. 931-4061 Lay-In/Medical/Duty Restrictions

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003. P-A-08 Communication on Special Needs Patients – *essential.*
B. IS22-1.1 Offender Authorized Personal Property
C. IS22-1.2 Offender Property Control Procedures

VI. HISTORY: This procedure was originally covered by IS11-69.1, Medical Permits until revised July 1, 1995, located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: April 1, 1992

A. Original Effective Date: April 1, 1992

B. Revised Effective Date: July 1, 1995

C. Revised Effective Date: November 4, 1998

D. Revised Effective Date: October 15, 1999

E. Revised Effective Date: October 22, 2004

F. Revised Effective Date: June 3, 2005

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

ATTACHMENT A

LAY-IN/MEDICAL/DUTY RESTRICTIONS

OFFENDER NAME	DOC NUMBER	INSTITUTION / DATE

CURRENT ASSIGNMENT	HOUSING UNIT

☐ FULL DUTY - No Restrictions - May Work In Food Service/Food Handling

	LIMITED DUTY OR MEDICAL RESTRICTION (Must Check Restrictions)	Permanent	Limited To (Date)	Able to Attend School, MOSOP Substance Abuse Classes	Able to Attend Work Activities
☐	Nonsmoking Roommate			☐ YES ☐ NO	☐ YES ☐ NO
☐	No Prolonged Standing Assignments			☐ YES ☐ NO	☐ YES ☐ NO
☐	Lifting Restrictions of _____ Pounds			☐ YES ☐ NO	☐ YES ☐ NO
☐	No High Places or Use of Ladders			☐ YES ☐ NO	☐ YES ☐ NO
☐	No Use of Chainsaws or Other Sharp Objects			☐ YES ☐ NO	☐ YES ☐ NO
☐	No Snow Shoveling			☐ YES ☐ NO	☐ YES ☐ NO
☐	☐ No or ☐ Limited Exposure to Cold			☐ YES ☐ NO	☐ YES ☐ NO
☐	Requires Lower Bunk			☐ YES ☐ NO	☐ YES ☐ NO
☐	Requires Lower Floor			☐ YES ☐ NO	☐ YES ☐ NO
☐	No Recreational Activities			☐ YES ☐ NO	☐ YES ☐ NO
☐	Can Work In Food Service But Cannot Handle Food			☐ YES ☐ NO	☐ YES ☐ NO
☐	Other			☐ YES ☐ NO	☐ YES ☐ NO

☐ MEDICALLY UNASSIGNED (Must Check One) Inmate is restricted to housing unit unless authorized for release to specific activities.

☐	Lay-In (Temporary Less Than 48 Hours)	End Date
	NURSE SIGNATURE	
☐	Permanent	
☐	Lay-In (Temporary Over 48 Hours)	End Date
	PHYSICIAN SIGNATURE	

DISTRIBUTION: White - Medical File Canary - Classification File via Classification Staff Pink - Work Site Goldenrod - Inmate

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-07 Emergency Plan Effective Date: August 13, 2004

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Randee Kaiser, Director
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I. **Purpose:** This procedure has been developed to identify areas of responsibility and appropriate responses of health care staff during an emergency/disaster and to ensure health care staff are prepared to implement the health aspects of the facility's emergency response plan.

A. **AUTHORITY:** 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institutions or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Deceased Group:** (black tag) Those who are dead or severely injured that only with prolonged and complex hospital would provide any chance for survival.

1. This includes irreversible shock, severe burns, critical central nervous system injuries, and critical injuries to the respiratory system.

2. These are the lowest priority and should receive the minimum of time expenditure.

3. Keep these persons as comfortable as possible.

B. **Delayed Treatment Group:** (yellow tag) Persons with spinal cord injury, multiple major fractures, moderate burns, or uncomplicated head injury.

C. **Designated Treatment Areas:** An area within the institution designated for the treatment of staff or offenders.

D. **Designated Triage Area:** The area of the institution designated for the triage of injured persons.

E. **Disaster Box:** A box containing medical supplies that can be utilized for emergency treatment.

F. **Emergency/Disaster:** Any event, man-made or natural (e.g., arson, tornado, flood, earthquake), including an internal disaster (e.g., riot, kitchen explosion), or external disaster (e.g., bomb threat, or power outage) of such magnitude that it significantly disrupts the normal function of the institution.

G. **Emergency Drug Box:** A box containing a stock of emergency medications.

H. **Hold Treatment Group:** (green tag) Persons who should not die if treatment is delayed such as all minor and uncomplicated fractures, wounds, other injuries, burns, and psychological problems.

I. **Immediate Treatment Group:** (red tag) Persons who need and should respond to immediate treatment such as airway-respiratory deficit, cardiac problem, uncontrolled hemorrhage, open chest-abdomen, severe head injury, reversible shock, and burns to 15-40% of body surface.

J. **Triage:** Assessment of patients for severity or priority of need to determine who is in need of help and who can wait or those that only with prolonged and complex hospital would provide any chance for survival due to the circumstance of the event.

K. **Mass Disaster Drill:** A simulated emergency/disaster involving multiple casualties that require triage by health staff. It frequently involves a natural disaster, an internal disaster, and/or external disaster.

L. **Man-Down Drill:** A simulated emergency affecting one individual who is in need of immediate medical intervention. It involves life-threatening situations commonly experienced in correctional settings.

M. **Critiques:** Review of drills or actual event to document activities including response time, names and titles of health staff, as well as the roles and responses of all participants. The review contains observations of appropriate and inappropriate staff responses to the drill.

III. PROCEDURES:

A. Institutional health care staff should participate in the development of an institutional emergency plan to ensure adequate medical assistance is provided.

B. Health care staff responsibilities in an emergency/disaster should be reviewed during orientation and annual inservice training sessions.

1. The health care staff should respond to an emergency/disaster according to the policies and procedures established by the institution and/or division.

C. In the event of an emergency/disaster, the senior ranking medical staff member should respond to the scene and, in cooperation with the designated security emergency coordinator, direct the medical team.

D. A call directory should be developed and distributed to all health care staff members, shift supervisor, and posted at the nurse's station.

1. The call directory should include the telephone numbers of health care staff, ambulance provider and hospitals and should be updated as needed, at least monthly.

E. On-site health care staff should notify the health services administrator/designee of an emergency/disaster.

F. Each institution will be assigned a Back-up Health Care Unit to provide primary materials and support in the event of a serious emergency/disaster.

1. While support from other units may later be warranted, it is intended that the assigned back-up health care unit be on first call and stand-by for assistance and or supplies upon notification of a serious emergency/disaster. Institutions have been designated as:

Site of Emergency/Disaster	Back-Up Health Services
ACC	JCCC/MSP
BCC	MCC
CCC	WMCC
CTCC	FRDC
CMCC	JCCC/MSP
CRCC	WMCC
ERDCC	FCC
FCC	ERDCC
FRDC	JCCC/MSP
JCCC/MSP	ACC and CMCC
MECC	ERDCC
MTC	WRDCC
MCC	BCC
NECC	WERDCC
OCC	SCCC
PCC	FCC
SECC	FCC
SCCC	FCC
TCC	JCCC/MSP
WERDCC	NECC
WMCC	CRCC
WRDCC	CRCC

G. Available health care staff should respond to the designated area.

1. The health care staff should maintain separate emergency/disaster and medical supplies that are to be checked monthly in accordance with institutional service procedure IS11-07.1 Disaster Box.

2. The health services administrator/designee should ensure the disaster box and emergency drug boxes are taken to the triage area.

3. Litters (waste containers/bags) should be brought to the disaster area by available health care and/or correctional staff.

H. A disaster box containing emergency/disaster supplies should be stored in a designated area.

1. Contents should be inventoried and checked monthly to ensure supplies do not expire. In accordance with institutional service procedure IS11-07.1 Disaster Box.

I. When notified of an emergency/disaster situation by correctional staff, the following information should be obtained, if available;

1. type of event,
2. number of estimated casualties,
3. location of event and
4. security of area.

J. In accordance with the institutional emergency plan, the superintendent/designee and medical director should determine the triage and treatment area.

1. If the medical area is involved in the disaster, the superintendent/designee and medical director should assign a secondary medical area.

K. The health services administrator/designee should assess the need for activating the local community emergency medical system.

L. The health services administrator/designee member should assess the need for additional health care personnel. The health services administrator/designee should make the decision to call in off-duty personnel and activate the emergency/disaster call-in list.

M. The health care staff should triage victims and direct assigned correctional staff to initiate life-saving procedures.

1. Triage designation should be:

a. Red Tag: immediate treatment group
b. Yellow Tag: delayed treatment group
c. Green Tag: hold treatment group
d. Black Tag: deceased group

N. The health services administrator/designee should assign an available health care person or assign a first-aid trained correctional officer to each RED and YELLOW tagged victim for first-aid and transportation to the treatment area or local hospitals.

O. All first aid and care rendered should be documented on the reverse side of the triage tags.

1. Triage tags should be stored in the disaster box.

P. The health care personnel who have been called in by activating the call-in list should move GREEN-tagged victims to the infirmary/transitional care unit clinic area for secondary triage and care.

Q. The infirmary/transitional care unit should be evacuated if directed by the superintendent/designee and the medical director.

R. Off-duty personnel who are called in should bring institutional ID badges and report to a specific area assigned by the health services administrator/designee and shift supervisor of custody.

S. The health care staff should not enter structurally unsafe or unsecured areas.

T. The health care staff should maintain lists of victims, movement and treatment.

U. The health care staff should participate in post-emergency/disaster critique process as indicated and requested using the Disaster Drill Evaluation format (Attachment A).

V. Health care staff not present or participating during a disaster drill will review and initial the written critiques.

W. A drill of the health care portion of the emergency plan should be practiced annually by all health care staff.

1. At least one mass disaster drill will be will be conducted annually in the facility changing the shift to ensure that over a 3-year period each shift has participated and evaluated utilizing the Disaster Drill Evaluation.

2. Security staff should participate with health care staff in planning and implementing of these drills.

3. The institutional safety manager, superintendent/designee, health services administrator, medical director, and others will evaluate the drill as determined by the institution's superintendent using the Disaster Drill Evaluation form

X. A health emergency man-down drill will be practiced once a year on each shift where health care staff is regularly assigned.

IV. ATTACHMENTS

A. Disaster Drill Evaluation Format

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-A-07, Emergency Response Plan – *essential.*
B. IS11-7.1 Disaster Box
C. IS24-1.2 Emergency Plan Procedures

VI. HISTORY: This procedure was originally covered by IS11-12.1, Disaster Plan Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date: October 6, 2003

D. Revised Effective Date: August 13, 2004

DISASTER DRILL EVALUATION FORMAT

Date of Report:

Evaluators:

Location of Drill:

Date and Time of Drill:

Scenario of Drill: (i.e., Describe the type of disaster, e.g., explosion, earthquake).

_____

_____

_____

Number and type of casualties: (e.g., one offender with fractured left humerus, one offender with depressed skull fracture, one offender with traumatic stress, and one staff with heart attack).

_____

_____

_____

List of community agencies involved with drill: e.g., AIRVAC, EMT, fire department, county hospital).

_____

_____

_____

Health Team's Response to Drill: (i.e., Description of personnel, time, equipment, coordination with security, transportation of injured, communication between staff and triage process).

_____

_____

_____

Disaster Drill Evaluation Format, Page 2

Have all staff on all shifts been allowed to participate in the disaster drill? Have they been advised of the results?

Recommendations for next year's drill: (e.g., different scenario, organization, notification).

Person Submitting Report:

Signature

****

MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-7.2 First Aid Kits Effective Date: August 13, 2004

Ralf Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. Purpose: This procedure ensures that supplies for immediate first aid needs are available in designated locations within the institution.

A. **AUTHORITY:** 217.175, 217.320 RSMo, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institutions or Division of Offender Rehabilitative Services. Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. DEFINITION:

None

III. PROCEDURES:

A. First aid kit will be maintained within each institution.

1. The health services administrator/designee should obtain approval for the contents of the first aid kits from the medical director.

2. Contents for the first aid kits should be approved by the medical director to include but not be limited to the following:

a. 3 pairs of disposable gloves (S,M,L)
b. 2 rolls adhesive tape
c. 2 roller gauze
d. 6 sponges

e. 1 triangular dressing
f. No medications should be stored in the first aid kits.

3. The superintendent/designee should determine the location of the kits.

4. The health care staff should refill items as requested by correctional staff on an as needed basis.

5. As items are used they should be logged on a usage sheet located inside the first aid kit with the date, item, and name of individual using the item for the purpose of recording usage and replacement.

6. The institutional safety manager should perform monthly inspections of first aid kits.

   a. Inspections should be documented on the First Aid Kit Monthly Inspection form (Attachment A).
   b. Kits should be restocked as necessary. (see III.4.)
   c. A copy of the inspection should be sent to the health services administrator.
   d. The original should be maintained by the institutional safety manager or the associate superintendent of the institution.

IV. ATTACHMENTS

A. 931-3800 First Aid Kit Monthly Inspection

V. REFERENCES:

A. National Commission on Correctional Health Care; Standards for Health Services in Prisons, 2003, P-A-01 Access to Care – *essential,* P-A-07 Emergency Response Plan – *essential.*

VI. HISTORY: This procedure was originally covered by IS11-27.1, First Aid Kits Procedure, located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date: August 13, 2004

Attachment A

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

FIRST-AID KIT MONTHLY INSPECTION

INSTITUTION

YEAR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
LOCATION												
Intact												
Refilled												
Initials												
LOCATION												
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MO 931-3800 (8-96) DISTRIBUTION: WHITE - MEDICAL UNIT CANARY - FIRE AND SAFETY INSPECTOR

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-07.1 Disaster Box

Effective Date: August 13, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. Purpose: This procedure ensures that sufficient medical supplies are available in case of an emergency or disaster.

A. **AUTHORITY:** 217.175, 217.320 RSMo, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institutions or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. DEFINITION:

A. **Disaster Box:** A box containing medical supplies to be utilized for emergency treatment.

III. PROCEDURES:

A. The institution superintendent/designee will ensure that a disaster box is provided to be used in case of an emergency/disaster situation with multiple injuries.

1. The medical director should determine the contents of the disaster box.

2. At a minimum the disaster box should contain the following:

a. CPR barrier mask
b. air splints
c. 4 x 4s
d. blankets
e. stretch bandages
f. butterfly closures
g. blood pressure cuff
h. stethoscope

i. flashlight and batteries
j. ambu-bag
k. iv fluids and set-ups
l. airway
m. combination pads
n. slings
o. saran wrap
p. trash bags
q. indelible markers
r. eye shield/goggles
s. impervious gown
t. disposable exam gloves
u. tourniquets
v. triage tags

3. The disaster box should be portable for easy transport to any area in the institution.

4. The disaster box should be sealed and placed in a strategic and secure area that is easily accessible by medical staff.

   a. The box should only be opened for an emergency/disaster or for restocking.

5. A list of contents with expiration dates should be affixed to the outside of the disaster box.

6. The health services administrator/designee should conduct monthly checks on the disaster box contents and replace supplies as needed.

   a. The list of contents will be updated as needed.

   b. Monthly checks should be recorded on the Safety Inspection Checklist or the First-Aid Kit Monthly Inspection form.

IV. ATTACHMENTS

A. 931-3814 Safety Inspection Checklist
B. 931-3800 First Aid Kit Monthly Inspection

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-A-07, Emergency Response Plan – *essential.*
B. IS11-7 Emergency Plan

VI. HISTORY: This procedure was originally covered by IS11-12.2, Disaster Box Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994
B. Revised Effective Date: October 15, 1999
C. Revised Effective Date: August 13, 2004

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

SAFETY INSPECTION CHECKLIST

SAFETY SUGGESTIONS	YES	NO	COMMENTS AND DEFICIENCIES NOTED AND ACTION REQUIRED	DATE CORRECTED
FLOORS ARE FREE FROM BREAKS, LOOSE TILES OR LINOLEUM, OR ANY OBSTRUCTION THAT MIGHT CAUSE PEOPLE TO STUMBLE OR FALL?				
EXIT SIGNS ARE LIT AND EGRESS ROUTES ARE POSTED?				
WARNING SIGNS ARE POSTED FOR RADIATION, ETC ?				
PASSAGEWAYS & HALLS ARE FREE OF BOXES OR OTHER ARTICLES BEING STORED?				
"NO SMOKING" SIGNS ARE POSTED?				
EMPLOYEES ARE OBSERVING "NO SMOKING" RESTICTIONS?				
RUBBISH, EMPTY CARTONS & PAPER ARE DISPOSED OF IMMEDIATELY?				
WET AREAS ARE BLOCKED OFF & A SIGN POSTED TO WARN PERSONS APPROACHING?				
FIRE EXTINGUISHERS ARE AVAILABLE AT STRATEGIC PLACES?				
EMPLOYEES ARE AWARE OF THE LOCATION OF THE EXTINGUISHER NEAREST THEM?				
FIRE EXTINGUISHER INSPECTIONS ARE CURRENT?				
EQUIPMENT, MATERIALS OR SUPPLIES ARE REMOVED WHEN THEY ARE NOT USED, OR BECOME OBSOLETE?				
ROUTINE INSPECTIONS OF EQUIPMENT ARE SCHEDULED FOR PROPER MAINTENANCE?				
X-RAY EQUIPMENT HAS BEEN INSPECTED?				
ELECTRICAL CORDS ARE IN GOOD CONDITION AND WITHOUT WORN PLACES?				
PLUMBING IS IN GOOD REPAIR, PREVENTING WATER SEEPAGE OR CONDENSATION THAT COULD CAUSE A WET OR SLIPPERY FLOOR?				
PROVISIONS ARE MADE FOR DISPOSAL OF BIOHAZARDOUS WASTE?				
NEEDLES & OTHER SHARP INSTRUMENTS ARE DISCARDED ONLY IN DESIGNATED CONTAINERS?				
REFRIGERATORS ARE CLEANED REGULARLY?				
MEDICINE, LAB, AND FOOD SPECIMENS ARE STORED SEPARATELY? SPECIMEN REFRIGERATOR MARKED BIOHAZARDOUS?				

MO 931-3814 (10-94)

DISTRIBUTION: **ORIGINAL** - MEDICAL UNIT **CANARY** - FIRE & SAFETY OFFICER

SAFETY SUGGESTIONS	YES	NO	COMMENTS AND DEFICIENCIES NOTED AND ACTION REQUIRED	DATE CORRECTED
TEMPERATURE OF REFRIGERATOR IS RECORDED DAILY IF USED FOR MEDICATIONS?				
MICROWAVE OVENS ARE CLEANED REGULARLY?				
ICE MACHINES ARE CLEAN, FREE OF RUST & NOT USED FOR FOOD STORAGE?				
SCOOPS USED FOR ICE ARE NOT STORED IN ICE CHEST?				
MEDICAL GAS CYLINDERS ARE CHAINED TO THE CARRIER TO PREVENT TIPPING?				
TANKS ARE SECURED EVEN WHEN EMPTY?				
A VALVE PROTECTION CAP IS IN PLACE WHEN OXYGEN IS NOT IN USE?				
HAZARDOUS EQUIPMENT IS PROPERLY GUARDED TO PREVENT ACCIDENTAL DISCHARGE?				
ACID & OTHER CHEMICALS ARE PROPERLY LABELED & SAFELY STORED & HANDLED?				
ALL SUBSTANCES ARE IN PROPERLY LABELED CONTAINERS?				
MATERIAL SAFETY DATA SHEETS (MSDS'S) ARE READILY AVAILABLE?				
STOREROOMS ARE ORDERLY?				
STOREROOMS ARE WELL LIGHTED?				
ARE EXITS & AISLES OF STOREROOMS CLEAR AT ALL TIMES?				
ALL STORAGE IS AT LEAST 18 INCHES BELOW SPRINKLER HEADS SO THAT SPRINKLER SYSTEM WILL WORK PROPERLY IN THE EVENT OF A FIRE?				
ALL ITEMS ARE STORED ON A SHELF OR A PALLET?				

SIGNATURE OF PERSON INSPECTING	DATE

MO 931-3614 (10-94)

DISTRIBUTION: ORIGINAL - MEDICAL UNIT CANARY - FIRE & SAFETY OFFICER

Attachment B

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
FIRST-AID KIT MONTHLY INSPECTION

INSTITUTION

YEAR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
CATION												
Intact												
Refilled												
Initials												
LOCATION												
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MO 931-3800 (8-96)

DISTRIBUTION: WHITE - MEDICAL UNIT CANARY - FIRE AND SAFETY INSPECTOR

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-06 Comprehensive-Continuous Quality Improvement Program

Effective Date: August 13, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. **Purpose:** This procedure has been developed to provide established objective criteria for a continuous quality improvement program to improve upon health care delivery, develop plans for improvement based on monitoring/ findings, and assess the effectiveness of those plans after implementation.

A. **AUTHORITY:** 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institutions or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Comprehensive-Continuous Quality Improvement (continuous quality improvement) Program:** A multidisciplinary quality improvement committee, monitoring of areas specified in the compliance indicators, and an annual review of the effectiveness of the continuous quality improvement program itself. The program should include a process quality improvement study, and an outcome quality improvement study, with both studies that may identify areas in need of improvement and effect remedial actions or strategies.

B. **Continuous Quality Improvement Committee:** A multidisciplinary group of health care professionals from various disciplines (e.g., medicine, nursing, mental health, dentistry, health records, pharmacy, laboratory) that designs quality improvement monitoring activities, discuss the results, and implements corrective action. The medical director or administrator shall be designated as chairperson for the committee. This committee will be responsible for program design to monitor and evaluate the delivery of health care to the offenders.

C. **Executive Continuous Quality Improvement Committee:** Membership shall include representatives from the division of offender rehabilitative services, health services, and mental health provider. At a minimum, the membership shall include the regional director of nursing, senior regional vice president/designee, regional medical director, and a member of the division of rehabilitative services contract monitoring team. The actual committee membership shall be determined and agreed upon by the executive committee during an annual meeting. The regional medical director shall serve as chair of the committee.

D. **Outcome Quality Improvement Studies:** An examination of whether expected outcomes of patient care were achieved.

E. **Physician Clinical Chart Review/Clinical Performance Enhancement:** An evaluation by a clinician of timeliness, appropriateness, and clinical care provided to patients.

F. **Process Quality Improvement Studies:** Examine the effectiveness of the health care delivery process.

G. **Sentinel Event:** Non-routine events that may involve health care services or health care staff (i.e., deaths, suicides, medication error, etc.)

III. PROCEDURES:

A. A quality improvement program and calendar of events should be developed annually based on Correctional Medical Services clinical program guidelines and specific institutional needs.

1. Quality improvement may be integrated into institutional medical audit committee meetings, although separate minutes for continuous quality improvement are required.

B. The continuous quality improvement committee should meet at least monthly and minutes and information be made distinct from any other meetings.

1. Meetings should be conducted monthly and be recorded in the following format:

a. attendance
b. guests
c. approval of previous minutes
d. review of follow-up items that are pending
e. presentation of scheduled reports of monitoring and evaluation activity in the **CRAFE** format.

C conclusion arrived at from assessment of process being evaluated
R recommendation to improve the process from the team and other members evaluating the process
A actions planned
F follow-up to assure recommended actions are taken
E evaluation of the actions for effectiveness

f. review of sentinel events
g. review of environmental/safety requirement
h. review of infection control committee

2. Intermediate summary meetings and minutes should be recorded in the following format:

a. attendance
b. guests
c. approval of previous meeting minutes
d. identification of trends
e. presentation of analysis of any action plans currently in place
f. evaluation of committee effectiveness for prior reporting period
g. compilation of intermediate summary reports for submission to the executive continuous quality improvement committee
h. recommendations for next reporting period

C. Annual summary meetings and minutes should be recorded in the following format:

a. attendance
b. guests
c. approval of previous meetings minutes
d. evaluation of committee effectiveness for the prior year
e. compilation of annual summary reports for submission to the executive continuous quality improvement committee

D. An agenda should be prepared and distributed at least 5 working days prior to the scheduled meeting.

1. Distribution should include each committee member, as well as the person responsible for each clinical service scheduled to report.

2. Minutes should be distributed to committee members, 7 working days following the meeting.

a. All continuous quality improvement minutes and audits shall be stamped as confidential.

E. The continuous quality improvement committee may review but not limited to the following area or process:

1. transitional care unit (infirmary care) tool as applicable,
2. chronic care clinic audit tool,
3. access to care,
4. receiving screening,
5. health assessment,
6. continuity of care,
7. nursing protocols,
8. pharmacy services,
9. diagnostic services,
10. mental health services,
11. dental services,
12. emergency services,
13. adverse patient occurrences (including all deaths),
14. critiques of disaster drills,
15. environmental inspections,
16. offender IRR/grievances,
17. infection control,
18. clinical outcomes/ peer reviews,
19. off-site specialty services,
20. patient satisfaction surveys,

F. The primary functions of the continuous quality improvement committee are to:

1. assign responsibility for continuous quality improvement activities to each clinical service provided at the facility,
2. integrate continuous quality improvement activities within and among clinical services,
3. assure that high risk, high volume, and problem prone processes of care are identified and evaluated,
4. assure indicators are relevant to the aspects of care,
5. establish a mechanism and calendar/schedule for reporting to the executive committee,
6. review the results of data collection to identify patterns/trends in problems/issues observed to increase the efficiency of the program and reduce duplication of activities,
7. ensure issues, once identified, are addressed,
8. assist in problem solving and encourage and facilitate a multidisciplinary approach,
9. ensure that each health service discipline (e.g., medical, dental, mental health, lab, and et.) maintains reporting compliance,
10. report continuous quality improvement activities to the executive quality improvement committee,
11. give feedback to health services units from the executive continuous quality improvement committee when appropriate,
12. review the effectiveness and responsibilities of the institutional continuous quality improvement committee and facility programs for revisions/changes.

G. The executive and each institutional health services continuous quality improvement committee should utilize the following steps for monitoring and evaluating the quality and appropriateness of care:

1. assign responsibility to implement the continuous quality improvement activities (management commitment and staff participation),
2. delineate the scope of services provided
3. identify the important aspects of care that affect the quality of care delivered and offer opportunities to improve care given,
4. use indicators that measure the quality of an important aspect of care,
5. use thresholds for evaluation of each indicator that indicates the acceptable level of performance,
6. collect and organize data,
7. evaluate care or services when thresholds are not attained,
8. take actions to improve care,
9. assess the effectiveness of actions taken, and
10. communicate the results.

H. The facility committee chairperson shall be responsible for forwarding monthly, intermediate summary and annual reports to the executive continuous quality improvement committee.

1. Monthly audit reports and continuous quality improvement minutes will be forwarded to the designated executive regional continuous quality improvement committee member by the 15th of each month for the prior month meeting and audits.

   a. In the event a monthly continuous quality improvement meeting is not held, a written memorandum to the regional executive continuous quality improvement committee member is required.

   b. The regional executive continuous quality improvement member/coordinator will be located at Correctional Medical Services regional office, Jefferson City, Missouri.

2. Intermediate summary reports will be forwarded to the executive continuous quality improvement committee.

   a. Summary reports and minutes are due the 15th day of the month following the summary meeting month.

3. The annual report will be submitted to the regional executive continuous quality improvement committee member.

   a. Summary reports and minutes are due by the 15th day of the month following the summary meeting month.

I. The executive continuous quality improvement committee shall meet at least quarterly. The agenda should include an assessment of each facility's continuous quality improvement reports as detailed in the continuous quality improvement manual.

1. Minutes shall be prepared and disseminated on a need to know basis as determined by the regional medical director and/or senior regional vice president.

2. Each facility shall receive written recommendations for any statewide issues that impact the quality of offender health care.

3. An annual meeting shall be devoted to an evaluation and summary of the continuous quality improvement program.

4. A report of the annual continuous quality improvement committee meeting should be presented to the director of the division of offender rehabilitation services (DORS) and Correctional Medical Services senior regional vice president.

J. The primary functions of the executive continuous quality improvement committee are to:

1. provide input, assistance, and recommendations to the department and health service contractor regarding issues of quality pertaining to offender/patient care provided within the correctional system,

2. evaluate the quality of offender/patient care by reviewing information on patterns, trends, problems in health care, and opportunities to improve care generated by each facility continuous quality improvement program,

3. assess whether recommendations for improvements are implemented and demonstrated improvements occur within a reasonable period of time,

4. ensure that each facility's program is being accomplished in an on-going systematic, comprehensive, coordinated, and integrated manner,

5. provide resources and support systems for the continuous quality improvement functions and risk management functions in a cost-efficient manner,

6. determine which issues have system-wide impact and facilitate problem-solving activities regarding these issues,

7. act as the primary means of oversight concerning adherence to rules and regulations, policy and procedure, and community standards,

8. review and evaluate the overall effectiveness of the continuous quality improvement program on an annual basis and prepare an executive summary for the department and Correctional Medical Services.

K. Quality improvement activities should be communicated at medical audit committee meeting by the health services administrator/designee.

L. All quality improvement activities should be handled in a confidential manner.

1. All continuous quality improvement documents should be marked "privileged and confidential".

IV. ATTACHMENTS

None

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-A-06 Continuous Quality Improvement Program – *essential.*

B. CMS and Missouri Department of Corrections Continuous Quality Improvement Program Manual.

VI. HISTORY: This procedure was originally covered by IS11-5.1, Quality Improvement Program Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A.	Original Effective Date:	August 15, 1994
B.	Revised Effective Date:	October 15, 1999
C.	Revised Effective Date:	October 6, 2003
D.	Revised Effective Date:	August 13, 2004

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-05 Policies and Procedures

Effective Date: August 13, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

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I. **Purpose:** To provide staff members with current direction concerning the official position of the health service operations on relevant issues and detailed guidelines concerning the manner in which policies and procedures are to be implemented.

A. **AUTHORITY:** 217.175, 217.320 RSMo, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Policy:** A definitive statement of the organization's position on an issue of concern to the administration or operation of the department or division.

B. **Procedure:** A detailed, step-by-step description of the sequence of activities necessary for the achievement of the policy which it demands.

C. **Standard Operating Procedure (SOP):** Site specific procedures developed at each institution in accordance with department policies and procedures, describing in detail how a policy and/or procedure is to be carried out.

III. **PROCEDURES:**

A. Institutional health services policies and procedures should be developed by Correctional Medical Services and department staff, based upon National Commission on Correctional Health Care

standards, American Correctional Association standards, Missouri statutes, and operational needs.

1. These policies and procedures should be reviewed by the compliance unit prior to being approved by the senior regional vice president, regional medical director, the director of adult institutions, the director of division of offender rehabilitative services and/or the director of the division of probation and parole.

B. Standard operating procedures specific to the provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health service providers, and the superintendent.

C. Approval Process: Each standard operating procedure should be reviewed and approved by the medical director, health services administrator, and superintendent/designee.

D. The current, original manual should be accessible and maintained in each clinic area by the health service administrator/designee, as well as in the superintendent; associate superintendent; policy and procedure coordinator's areas and other areas designated by the superintendent in the system to provide for continuous access to policies and procedures.

E. The health services administrator should ensure that the manual is current at all times.

F. The health services administrator, and medical director, and superintendent should review the manual annually.

1. Policies and procedures review documentation will be a signed and dated declaration that the entire manual has been reviewed and approved.

G. Revised or additional policies and procedures should be presented at monthly staff meetings and posted on appropriate bulletin boards for 30 days prior to inclusion in the manual, unless it is an emergent or critical change.

H. Staff members should indicate their review of policies and procedures by signing on a signature sheet provided by the health services administrator.

I. A copy of obsolete or revised policies and procedures, with a notation of the date of change, should be retained and kept on file in the health services unit.

J. A copy of the policy and procedure manual and revised material should be sent to Correctional Medical Service corporate office directed to the attention of clinical programs division in the event of contract service termination.

K. Development of standard operating procedures for mental health services shall be the responsibility of the institutional chief of mental health services.

IV. ATTACHMENTS

None

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003. P-A-05, Policies and Procedures - *essential.*

VI. HISTORY: This procedure was originally covered by IS11-4.1, Policy and Procedures located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A.	Original Effective Date:	August 15, 1994
B.	Revised Effective Date:	October 15, 1999
C.	Revised Effective Date:	August 18, 2003
D.	Revised Effective Date:	August 13, 2004

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-04 Administrative Meetings And Reports

Effective Date: August 13, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. Purpose: This procedure has been developed to provide guidelines to ensure on-going communication and cooperative efforts between institutional and health services professionals.

A. **AUTHORITY:** 217.175, 217.320 RSMo, National Commission on Correctional Health Care standards for health services in prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. DEFINITION:

None

III. PROCEDURE:

A. Administrative meetings and reports shall be conducted on a regular basis with typed minutes and reports. The meeting minutes and reports should be completed timely and accurately as required by procedure and contractual requirements.

B. Monthly meetings and reports should include distribution of information as outlined by procedural and contractual requirements.

IV. ATTACHMENTS

None

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003. P-A-04, Administrative Meetings and Reports – *essential.*

VI. HISTORY: This procedure was originally covered by IS11-3, Administrative Meetings and Reports located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date: **August 13, 2004**

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-04.3 Health Services Report-Prisons Effective Date: **August 13, 2004**

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. **Purpose:** This procedure provides guidelines for reporting a summary of monthly health care statistics to correctional medical service administrative staff, superintendent/designee and division of offender rehabilitative services administrative staff.

A. **AUTHORITY:** 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Health Services Report:** A summary of monthly health services statistics to include medical, dental, and mental health; medical and dental statistics will be reported on the "Health Services Report" attachment A, "Health Services Data Survey" attachment B, "Mental Health Services Report" attachment C, and "Mental Health Services Data Survey" attachment D.

III. **PROCEDURES:**

A. The health services administrator or designee should complete the Health Services Report Data Survey on a monthly basis.

1. The Health Services Report Data Survey information is formatted into the Health Services Report by means of the computer program-Microsoft Excel.

   a. Health services reporting will be submitted on the Health Services Report.

   b. Mental health services reporting will be submitted on the Mental Health Services Report.

2. The Health Services Report Data Survey must be submitted on the Health Services Report form.

3. The Health Services Report should be approved and signed by the health services administrator.

4. The Health Services Report should be submitted to the senior regional vice president/designee by noon on the 3rd work day of the month following the reported month, i.e., June's statistics will be reported in July. The senior regional vice president/designee will forward copies of monthly reports to the contract monitoring team

5. A copy of the Health Services Report should be provided to attendees of the medical audit committee meetings.

6. The following demographic data should be completed at the top of the first page:

   a. name of preparer,
   b. signature of health services administrator,
   c. institution name,
   d. month and year of reported data,
   e. average daily offender census,
   f. male/female ratio, and
   g. area and region.

7. The body of the Health Services Report should be completed according to the questions provided.

8. All questions of the Health Services Report should be answered. The actual numbers, a "0" if no data; N/A should not be inserted on a data line. If question does not apply, a "0" should be entered.

9. Once the information is completed the report should be printed and distributed.

IV. ATTACHMENTS

A. Health Services Report format
B. Health Services Report Data Survey format
C. Mental Health Services Report format
D. Mental Health Services Report Data Survey format

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-A-04 Administrative Meetings and Reports – *essential.*

VI. HISTORY: This procedure was originally covered by IS11-3.3 Health Services Reports – Prisons (Statistical) Procedure, located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994
B. Revised Effective Date: October 15, 1999
C. Revised Effective Date: August 13, 2004

Attachment A
IS11-04.3 Health Services Report

State of Missouri

Health Services Report
Sept. 2003 Version

ITY 0

EA REGION Missouri

MONTH

AVERAGE DAILY INMATE CENSUS 0

PREPARER

SITE ADMINISTRATOR

DATE PREPARED

Males: 0 Females: 0

CLINICAL VISITS

	PHYSICIAN	PA/NP	NURSING	DENTAL	DENTIST
1. CLINICAL VISITS	0	0	0	0	0
2. SEGREGATION VISITS	0	0	0		
3. INTAKE SEGREGATION VISITS			0		

ANNUAL PHYSICALS THAT ARE OVERDUE	0
TRIENNIAL PHYSICALS THAT ARE OVERDUE	0

EMS & HOSPITAL UTILIZATION

1. # OF INMATES TRANSPORTED ANYWHERE BY AMBULANCE	0
2. # OF INMATES SENT TO ER	0
3. TOTAL HOSPITAL ADMISSIONS	0
4. TOTAL IN-PATIENT DAYS FOR THIS MONTH	0

DENTAL

1. # OF INMATES RECEIVING DENTAL X-RAYS	0
2. # OF 30 DAY DENTAL EXAMS	0
3. # OF EXTRACTIONS	0
4. # OF FILLINGS	0
Of INMATES RECEIVING DENTAL CARE	0

ARMACY

1. # OF INMATES ON RX MEDICATION	0
2. # OF INMATES ON PSYCHOTROPIC MEDICATION	0

INFIRMARY HOUSING

1. # OF INFIRMARY BEDS AT YOUR SITE	0
2. # OF INMATES ADMITTED TO INFIRMARY	0
3. # OF INMATES IN INFIRMARY FROM PREVIOUS MONTH	0
4. # OF PERMANENT INFIRMARY PATIENTS	0
5. # OF TOTAL INFIRMARY DAYS AT YOUR SITE	0

SPECIALISTS

	ON-SITE	OFF-SITE
1. DERMATOLOGY	0	0
2. DIALYSIS	0	0
3. OB /GYN	0	0
4. INTERNAL MEDICINE	0	0
5. NEUROLOGY	0	0
6. OCCUPATIONAL THERAPY	0	0
7. OPTHAMOLOGY	0	0
8. RADIATION THERAPY	0	0
9. OPTOMETRY	0	0
10. ORAL SURGERY	0	0

CHRONIC CARE CLINICS

	PHYSICIAN	NURSE	# Enrolled
1. CARDIOVASCULAR	0	0	0
2. PULMONARY-Asthma	0	0	0
3. INFECTIOUS DISEASE - TB	0	0	0
4. ENDOCRINE-DM	0	0	0
5. NEUROLOGY	0	0	0
6. INTERNAL MEDICINE	0	0	0
7. HYPERTENSION	0	0	0
8. SEIZURE DISORDER	0	0	0
9. INFECTIOUS DISEASE - NOT TB	0	0	0
10. SPECIAL NEEDS	0	0	0
11. Pulmonary-Non-Asthma	0	0	0
12. Endocrine-Non-DM	0	0	0
13. HEPATITIS C	0	0	0

ANCILLIARY SERVICES

1. # OF HIV / RPR TESTS DRAWN	0
2. # OF MAMMOGRAMS	0
3. # OF PAP SMEARS	0
4. # OF INMATES X-RAYED	0
5. # OF INMATES FOR WHOM LAB WAS ORDERED	0
6. # OF LAB TESTS OTHER THAN HIV / RPR	0

	RECEIVED this Month	INCOMPLETE
IRRS	0	0
GRIEVANCES	0	0

MISCELLANEOUS

1. # OF DEATHS DURING THE MONTH	0
2. # OF SELF-DECLARED EMERGENCIES	0

	ON-SITE	OFF-SITE
11. ORTHOPEDICS	0	0
12. ENT	0	0
13. PHYSICAL THERAPY	0	0
14. PSYCHIATRY	0	0
15. PODIATRY	0	0
16. UROLOGY	0	0
17. SPECIALITY RADIOLOGY	0	0
18. ONCOLOGY	0	0
19. OUTPATIENT SURGERY	0	0
20. OTHER	0	0

Attachment B
IS11-04.3 Health Services Report Data
Survey

	A	B	C											
1	********** HSR DATA SURVEY July 2003 - June 2004 (Sept 2003 version) **********													
2														
3	1. WHAT IS THE NAME OF YOUR FACILITY?													
4	2. WHAT AREA ARE YOU IN (West, Central, North or East) "Your Missouri Area" West: CRCC, MCC, MTC, OCC, WMCC, WROCC North: CCC, WERDCC Central: ACC, BCC, CMCC, CTCC, FRDC, JCCC, TCC East: ERDCC, FCC, PCC, MECC, NECC, SCCC, SECC													
5	WHAT REGION ARE YOU IN?	Missouri	Missouri	Missouri	Missouri	Missouri	Missouri	Missouri	Missouri	Missouri	Missouri	Missouri	Missouri	Missouri
6	WHAT MONTH DOES THIS REPORT REFLECT?													
7	WHAT IS THE NAME OF THE PREPARER AND TITLE? Per Regional Manager, reports are to be completed by the site administrator. If site administrator is off-site or PTO, then must be acting administrator.													
8	6. WHO IS THE SITE ADMINISTRATOR THAT REVIEWED THIS FORM? Should be same as preparer.													
9	7. WHAT DATE WAS THIS REPORT PREPARED?													
10	8. WHAT IS YOUR AVERAGE DAILY CENSUS? This will reflect the MoDOC report to AP. The Regional Office will provide this to you.													
11	9. OF YOUR AVERAGE DAILY CENSUS, HOW MANY WERE MALES? Do NOT use %. Use number or "0"													
12	10. OF YOUR AVERAGE DAILY CENSUS, HOW MANY WERE FEMALES? Do NOT use %. Use number of "0"													
13														
14	11. HOW MANY INMATES WERE SEEN BY THE SITE PHYSICIAN? (Exclude specialist visits and Segregation Encounters.)													
15	12. HOW MANY INMATES IN SEGREGATION WERE SEEN BY THE SITE PHYSICIAN?													
16														
17	13. NP/PA (Nurse Practitioner/Physician Assistant) ENCOUNTER OTHER THAN SEGREGATION ENCOUNTERS AT YOUR SITE?													
18	14. NP/PA (Nurse Practitioner/Physician Assistant) SEGREGATION ENCOUNTERS AT YOUR SITE?													
19	15. ALL NURSES ENCOUNTERS AT YOUR SITE? If the (inmate contact) nurse documented an encounter in MARS or progress notes, it is included in this number. Although must be done per a SOAP note. VS/BP checks, medication counseling – not medication pick-up of any kind. HIV post test/pre test counseling if by SOAP note or protocol in MARS used. Infirmary encounters are only to be counted as one per shift (Example: 4 patients on shift are 4 encounters, not the number of times you chart.) TB history or S&Bs utilizing SOAP note/protocols. OTC medication issue is counted if using non-prescription in MARS and protocols. Neuro checks are only counted per patient, per shift x 1, since this individual would be in the Infirmary, count as infirmary count. Sickle Cell counseling is only counted if SOAP note and done by your site nurse. Do not count encounters here that are included in another response (if you use MARS query to get numbers, progress notes are not picked up by these queries.) Self-declared emergencies seen and not seen. Not seen but required review and assessment to refer to MSR and documented.													
20	16. DENTAL ENCOUNTERS AT YOUR SITE? This includes dental assistants seeing patients not being referred to see the dentist the same day. This is also when a dentist is not available but the dental assistant sees the patient with documentation/assessment of the encounter in progress.													
21	17. HOW MANY INMATES RECEIVED DENTAL CARE AT YOUR FACILITY BY THE DENTIST ONLY?													
22														
23	18. HOW MANY INMATES WERE SEEN DURING SEGREGATION UNIT NURSING ROUNDS AT YOUR SITE? This count is from the segregation check-off form or MARS segregation protocol. Must be a documented encounter. Remember if you use a MARS query, you need to subtract from nurse encounter/sick call number because MARS does not distinguish from the specific protocol encounter for general queries.													
24	19. HOW MANY INMATES DID NURSING SEE FOR SEGREGATION UNIT INTAKE PLACEMENT AT YOUR SITE? Number of inmates examined before, at the time of or shortly after placement in the segregation unit. Completed intake history, placement form or protocol. If an inmate refuses examination, nurse must still complete form or protocol.													
25	20. HOW MANY ANNUAL PHYSICALS ARE OVERDUE FOR THIS MONTH? (Annual physical are required for offenders that 50 or older OR they ARE enrolled in a chronic care clinic.)													
26	21. HOW MANY TRIENNAL PHYSICALS ARE OVERDUE FOR THIS MONTH? (Triennial physicals are required for offenders that under 50 AND are NOT enrolled in a chronic care clinic.)													
27														
28	22. HOW MANY INFIRMARY BEDS ARE THERE AT YOUR SITE? If you do not have an infirmary bed, respond with a "0" number, do not use N/A or None.													
29	23. HOW MANY INMATES WERE ADMITTED TO YOUR INFIRMARY DURING THIS MONTH?													
30	24. HOW MANY INMATES WERE STILL IN THE INFIRMARY FROM THE PREVIOUS MONTH?													
31	25. HOW MANY PERMANENT INFIRMARY PATIENTS DO YOU HAVE?													
32	26. HOW MANY TOTAL INFIRMARY DAYS WERE INCURRED AT YOUR FACILITY? Total including all patient days. Also include carry-over days from previous month.													
33	27. HOW MANY HIV/RPR LABORATORY STUDIES WERE DRAWN AT YOUR FACILITY?													
34	28. HOW MANY PAP SMEARS WERE PERFORMED AT YOUR FACILITY?													
35	29. HOW MANY IRRs DID YOU RECEIVE THIS MONTH?													
36	30. HOW MANY IRRs ARE INCOMPLETE AT THIS TIME?													
37	31. HOW MANY GRIEVANCES DID YOU RECEIVE THIS MONTH?													
38	32. HOW MANY GRIEVANCES ARE INCOMPLETE AT THIS TIME?													
39														
40	33. HOW MANY OF YOUR INMATES EXPIRED THIS MONTH?													
41	34. HOW MANY TOTAL INMATES RECEIVED MAMMOGRAMS? Include mobile unit mammograms here.													
42	5. HOW MANY OF YOUR INMATES WERE TRANSPORTED ANYWHERE BY AMBULANCE?													
43	1. HOW MANY OF YOUR INMATES WERE SENT TO THE ER? Sent by Car or Ambulance													
44	7. TOTAL NUMBER OF HOSPITAL ADMISSIONS FROM THIS SITE?													
45	38. TOTAL NUMBER OF IN-PATIENT DAYS THIS MONTH?													
46	39. HOW MANY OF YOUR INMATES HAD OUTPATIENT SURGERY AT A COMMUNITY HOSPITAL? Includes "free standing surgical centers."													
47	40. HOW MANY OF YOUR INMATES HAD SURGERY AT YOUR FACILITY? On-site surgical procedures. (Non-Dental)													
48														
49	41. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR C1 - CARDIOVASCULAR CCC?													
50	42. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR C1 - CARDIOVASCULAR CCC?													
51	43. HOW MANY OF YOUR INMATES ARE ENROLLED IN C1 - CARDIOVASCULAR CCC?													
52														
53	44. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR C2 - PULMONARY CCC?													
54	45. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR C2 - PULMONARY CCC?													
55	46. HOW MANY OF YOUR INMATES ARE ENROLLED IN C2 - PULMONARY CCC?													
56														
57	47. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR C3 - INFECTIOUS DISEASE TB CCC?													
58	48. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR C3 - INFECTIOUS DISEASE TB CCC?													
59	49. HOW MANY OF YOUR INMATES ARE ENROLLED IN C3 - INFECTIOUS DISEASE TB CCC?													
60														
61	50. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR C4 - ENDOCRINE CCC?													
62	51. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR C4 - ENDOCRINE CCC?													
63	52. HOW MANY OF YOUR INMATES ARE ENROLLED IN C4 - ENDOCRINE CCC?													
64														
65	53. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR C5 - NEUROLOGY CCC?													
66	54. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR C5 - NEUROLOGY CCC?													
67	55. HOW MANY OF YOUR INMATES ARE ENROLLED IN C5 - NEUROLOGY CCC?													
68														
69	56. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR C6 - INTERNAL MEDICINE CCC?													
70	57. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR C6 - INTERNAL MEDICINE CCC?													
71	58. HOW MANY OF YOUR INMATES ARE ENROLLED IN C6 - INTERNAL MEDICINE CCC?													
72														
73	59. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR C7 - HYPERTENSION CCC?													
74	60. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR C7 - HYPERTENSION CCC?													
75	61. HOW MANY OF YOUR INMATES ARE ENROLLED IN C7 - HYPERTENSION CCC?													
76														
77	62. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR C8 - SEIZURE DISORDER CCC?													
78	63. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR C8 - SEIZURE DISORDER CCC?													
79	64. HOW MANY OF YOUR INMATES ARE ENROLLED IN C8 - SEIZURE DISORDER CCC?													
80														
81	65. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR C9 - INFECTIOUS DISEASE NOT TB CCC?													
82	66. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR C9 - INFECTIOUS DISEASE NOT TB CCC?													
83	67. HOW MANY OF YOUR INMATES ARE ENROLLED IN C9 - INFECTIOUS DISEASE NOT TB CCC?													
84														
85	68. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR C0 - SPECIAL NEEDS CCC?													
86	69. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR C0 - SPECIAL NEEDS CCC?													
87	70. HOW MANY OF YOUR INMATES ARE ENROLLED IN C0 - SPECIAL NEEDS CCC?													
88														
89	71. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR CD - PULMONARY-NON-ASTHMA CCC?													
90	72. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR CD - PULMONARY-NON-ASTHMA CCC?													
91	73. HOW MANY OF YOUR INMATES ARE ENROLLED IN CD - PULMONARY-NON-ASTHMA CCC?													
92														
93	74. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR CE - ENDOCRINE-NON-DM CCC?													
94	75. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR CE - ENDOCRINE-NON-DM CCC?													
95	76. HOW MANY OF YOUR INMATES ARE ENROLLED IN CE - ENDOCRINE-NON-DM CCC?													
96														
97	77. HOW MANY OF YOUR INMATES WERE SEEN BY A PHYSICIAN FOR CY - HEPATITIS C CCC?													
98	78. HOW MANY OF YOUR INMATES WERE SEEN BY A NURSE FOR CY - HEPATITIS C CCC?													
99	79. HOW MANY OF YOUR INMATES ARE ENROLLED IN CY - HEPATITIS C CCC?													
100														
101	80. HOW MANY INMATES DO YOU HAVE WHO ARE ON PRESCRIBED MEDICATION?													
102	81. HOW MANY INMATES DO YOU HAVE WHO ARE ON PSYCHOTROPIC MEDICATION?													
103														
104	82. HOW MANY OF YOUR INMATES WERE SEEN FOR A DERMATOLOGY CLINIC AT A MoDOC FACILITY?													
105	83. HOW MANY OF YOUR INMATES WERE SEEN FOR A DERMATOLOGY CLINIC IN THE COMMUNITY?													
106														
107	84. HOW MANY OF YOUR INMATES WERE SEEN FOR DIALYSIS AT A MoDOC SITE?													
108	85. HOW MANY OF YOUR INMATES WERE SEEN FOR DIALYSIS IN THE COMMUNITY?													
109														
110	86. HOW MANY OF YOUR INMATES WERE SEEN FOR AN OB/GYN CLINIC AT A MoDOC SITE?													
111	87. HOW MANY OF YOUR INMATES WERE SEEN FOR AN OB/GYN CLINIC IN THE COMMUNITY?													
112														

	A	B	C	D	E	F	G	H	I	J	K	L	M
112	88. HOW MANY OF YOUR INMATES WERE SEEN FOR AN INTERNAL MEDICINE CLINIC AT A MoDOC SITE?												
113	89. HOW MANY OF YOUR INMATES WERE SEEN FOR AN INTERNAL MEDICINE CLINIC IN THE COMMUNITY?												
114													
115	90. HOW MANY OF YOUR INMATES WERE SEEN FOR A NEUROLOGY CLINIC AT A MoDOC SITE?												
116	91. HOW MANY OF YOUR INMATES WERE SEEN FOR A NEUROLOGY CLINIC IN THE COMMUNITY?												
117													
118	92. HOW MANY OF YOUR INMATES WERE SEEN FOR AN OCCUPATIONAL THERAPY CLINIC AT A MoDOC SITE?												
119	93. HOW MANY OF YOUR INMATES WERE SEEN FOR AN OCCUPATIONAL THERAPY CLINIC IN THE COMMUNITY?												
120													
	94. HOW MANY OF YOUR INMATES WERE SEEN FOR AN OPHTHALMOLOGY CLINIC AT A MoDOC SITE? Know the difference between optometry and ophthalmology. Opthamology is usually an off-site specialty visit. Optometry is the contractor.												
	95. HOW MANY OF YOUR INMATES WERE SEEN FOR AN OPTHALMOLOGY CLINIC IN THE COMMUNITY?												
123	96. HOW MANY OF YOUR INMATES WERE SEEN FOR AN OPTOMETRY CLINIC AT A MoDOC SITE?												
124	97. HOW MANY OF YOUR INMATES WERE SEEN FOR AN OPTOMETRY CLINIC IN THE COMMUNITY?												
125													
126	98. HOW MANY OF YOUR INMATES WERE SEEN FOR AN ORAL SURGERY CLINIC AT A MoDOC SITE?												
127	99. HOW MANY OF YOUR INMATES WERE SEEN FOR AN ORAL SURGERY CLINIC IN THE COMMUNITY?												
128													
129	100. HOW MANY OF YOUR INMATES WERE SEEN FOR AN ORTHOPEDIC CLINIC AT A MoDOC SITE?												
130	101. HOW MANY OF YOUR INMATES WERE SEEN FOR AN ORTHOPEDIC CLINIC IN THE COMMUNITY?												
131	102. HOW MANY OF YOUR INMATES WERE SEEN FOR AN ENT CLINIC AT A MoDOC SITE?												
132	103. HOW MANY OF YOUR INMATES WERE SEEN FOR AN ENT CLINIC IN THE COMMUNITY?												
133													
134	104. HOW MANY OF YOUR INMATES WERE SEEN FOR A PHYSICAL THERAPY CLINIC AT A MoDOC SITE? Does not include therapy done by nursing staff. Count the number of actual completed visits per patient seen by the therapist. Example: One individual requires therapy 2x per week on Monday and Thursday for the month. One patient 2x per week for 4 weeks – the number to record here is 8 or the number of actual sessions/visits for the reporting month.												
135	105. HOW MANY OF YOUR INMATES WERE SEEN FOR A PHYSICAL THERAPY CLINIC IN THE COMMUNITY?												
136													
137	106. HOW MANY OF YOUR INMATES WERE SEEN FOR A PSYCHIATRY CLINIC AT A MoDOC SITE?												
138	107. HOW MANY OF YOUR INMATES WERE SEEN FOR A PSYCHIATRY CLINIC IN THE COMMUNITY?												
139													
140	108. HOW MANY OF YOUR INMATES WERE SEEN FOR A PODIATRY CLINIC AT A MoDOC SITE?												
141	109. HOW MANY OF YOUR INMATES WERE SEEN FOR A PODIATRY CLINIC IN THE COMMUNITY?												
142													
143	110. HOW MANY OF YOUR INMATES WERE SEEN FOR A UROLOGY CLINIC AT A MoDOC SITE?												
144	111. HOW MANY OF YOUR INMATES WERE SEEN FOR A UROLOGY CLINIC IN THE COMMUNITY?												
145													
146	112. HOW MANY OF YOUR INMATES WERE SEEN FOR A SPECIAL RADIOLOGY CLINIC AT A MoDOC SITE? Example: A radiologist would come to your site or to another site and perform a fluoroscopy x-ray procedure – this is a special radiology procedure.												
147	113. HOW MANY INMATES WERE SEEN FOR A SPECIAL RADIOLOGY CLINIC (i.e., Ultrasound, CAT Scan, and MRI) IN THE COMMUNITY?												
148													
149	114. HOW MANY OF YOUR INMATES WERE SEEN FOR A RADIATION THERAPY CLINIC AT A MoDOC SITE?												
150	115. HOW MANY OF YOUR INMATES WERE SEEN FOR A RADIATION THERAPY CLINIC IN THE COMMUNITY?												
151													
152	116. HOW MANY OF YOUR INMATES WERE SEEN FOR AN ONCOLOGY/CHEMOTHERAPY CLINIC AT A MoDOC SITE?												
153	117. HOW MANY OF YOUR INMATES WERE SEEN FOR AN ONCOLOGY/CHEMOTHERAPY CLINIC IN THE COMMUNITY?												
154													
155	118. HOW MANY OF YOUR INMATES WERE SEEN FOR ANY OTHER CLINIC AT A MoDOC SITE?												
156	119. HOW MANY OF YOUR INMATES WERE SEEN FOR ANY OTHER CLINIC IN THE COMMUNITY?												
157													
158	120. HOW MANY SELF-DECLARED EMERGENCIES OCCURRED DURING THIS MONTH?												
159													
160	121. HOW MANY TOTAL INMATES RECEIVED DENTAL X-RAYS AT YOUR FACILITY?												
161	122. HOW MANY TOTAL TEETH WERE EXTRACTED AT YOUR FACILITY?												
162	123. HOW MANY TOTAL TEETH WERE FILLED AT YOUR FACILITY?												
163	124. HOW MANY TOTAL INMATES RECEIVED 30-DAY DENTAL EXAMS AT YOUR FACILITY? Generally applies to diagnostic sites.												
164	125. How many inmates received dental services												
165	126. HOW MANY OF YOUR INMATES WERE X-RAYED AT ANOTHER FACILITY? This is how many of your inmates were sent to another DOC site for x-rays. How many inmates not how many x-rays.												
166	127. HOW MANY OF YOUR INMATES WERE X-RAYED AT A COMMUNITY PROVIDER? Sent to a local hospital or clinic for xray – not another prison. *Colonoscopy / Endoscopy is an outpatient surgery – not xray.												
167	128. WHAT WAS THE TOTAL NUMBER OF INMATES X-RAYED AT YOUR FACILITY? Count by orders: If one inmate had a chest & arm xray this counts as 2 (two). Although the question is how many inmates the number wanted is the utilization of radiology/xray services. Includes x-rays done at your site by mobile xray services.												
168	129. HOW MANY INMATES HAD LAB STUDIES ORDERED? How many inmates Not how many lab studies. *(This number should be less than the number of other lab studies that were drawn at your facility – (questions # 130+# 131+ # 132 below.)												
169	130. HOW MANY HIV/RPR LAB STUDIES WERE DRAWN AT YOUR FACILITY?												
170	131. HOW MANY PAP SMEARS WERE PERFORMED AT YOUR FACILITY?												
171	132. HOW MANY OTHER LAB STUDIES WERE DRAWN AT YOUR FACILITY? Other than HIV / RPR / PAP. Count lab studies not tubes. Ex: CBC / SMAC / PT = 3 studies.												

MISSOURI REGION
MENTAL HEALTH SERVICES REPORT

FACILITY		**ADMINISTRATOR**	
MONTH		**INST CHIEF**	
PT. POPULATION	0	**DATE PREPARED**	

CLINICAL VISITS	PSYCHIATRIST	NURSING	ACTIVITY THERAPIST	MASTERS LEVEL	PSYCHOMETRIST	LICENSED PSYCHOLOGIST
1. INTAKE	0		0	0	0	0
2 INITIAL	0			0		0
3. F/U	0			0		0
4. INDIVIDUAL		0	0	0		0
5. GROUP		0	0	0		0
6. INITIAL TX PLAN				0		0
7. REVISED TX PLAN				0		0
8. CHRONIC CARE	0	0		0		0
9. CRISIS INTERVENTION	0	0		0		0
10. SEG ROUNDS				0		0
11. SUICIDE INT.				0		0
12. 30 DAY SEG				0		0
13. 90 DAY TX PLAN				0		0
TOTAL ENCOUNTERS	0	0	0	0	0	0
TOTAL OFFENDERS	0	0	0	0	0	0

NUMBER OF OFFENDERS ON PSYCH MEDS	0	IRRS	0
% OF POPULATION ON PSYCH MEDS	0.00%	GRIEVANCES	0
% OF OFFENDERS ON PSYCH MEDS	0.00%	MH Access	0
		MD Access	0

Unduplicated MH1-2	0		
Unduplicated MH3	0		
Unduplicated MH4	0		
Unduplicated MH5	0		

EVENTS	Admissions	DC's
BIGGS	0	0
CTC	0	0
SRU	0	0
WSRU	0	0
PCC	0	
SNU	0	0

EVENTS	
COMPLETED SUICIDES	0
SR1	0
SR 2	0
SR 3	0
Forced Meds	0
Close Observation	0
Suicide Watch	0

PATIENTS	
SEG MH3	0
SEG MH4	0
SR 3	0
# in Group Therapy	0
Involuntary Meds	0

Tests	
MMPI	0
Wechsler	0
Other IQ	0
Other	0

Mental Health - Health Services Report Data Survey

Question #		Answer #	Answer #	Answer #	Answer #
1	What is the name of your facility?				
2	Who is the Health Services Administrator at your facility?				
3	What month does the data to be entered represent? (Current reporting month)				
4	Who is the institutional Chief of Mental Health Services at your facility?				
5	What is the average population at your facility for the current reporting month? *Obtained from Regional Office Report*				
6	What date was this report prepared?				
7	How many intake visits did your psychiatrist(s) do this month? *Reception Centers and PCC (capital punishment) only.*				
8	How many initial visits did your psychiatrist(s) do this month? *Count only visits where the patient has not seen a psychiatrist in the last 6 months.*				
9	How many follow-up visits did your psychiatrist(s) do this month? *Count only regularly scheduled visits.*				
10	How many Chronic Care Clinic visits did your psychiatrist(s) do this month? *Count only visits when the patient is enrolled or being enrolled in Chronic Care and being seen within the context on Chronic Care pathways.*				
11	How many crisis intervention visits did your psychiatrist(s) do this month? *Count only unscheduled visits when the patient was seen on an urgent or emergent basis.*				
12	How many patients (unduplicated) did your psychiatrist(s) see this month? *Each different offender seen is only counted once.*				
13	How many individual encounters did your psychiatric nurse do this month? *Count only those scheuled encounters which generated a SOAP note.*				
14	How many group encounters did your psychiatric nurse do this month? *Count every patient who attended a group. For ongoing groups patients will be counted each time they attended a group.*				
15	How many Chronic Care Clinic visits did your psychiatric nurse do this month? *Count only those patients being admitted to or already admitted to Chronic Care and being seen within the Chronic Care pathways.*				
16	How many crisis intervention visits did your psychiatric nurse do this month? *Count only unscheduled visits of an urgent or emergent nature where a SOAP note was generated.*				
17	How many patients (unduplicated) did your psychiatric nurse see this month? (Do not include Group Therapy.) *Each different offender seen is only counted once.*				
18	How may initial visits did your activity therapist do this month? *Count only new visits*				
19	How may individual encounters did your activity therapist do this month?				
20	How many group contacts did your activity therapist have this month? *Count every patient who attended a group. For ongoing groups patients will be counted each time they attend a group.*				
21	How many total (unduplicated) patients did your activity therapist see this month? (Do not include Group Therapy.)*Each different offender is counted only once.*				
22	How many intake encounters did your Master's level therapist have this month? *Reception Centers and PCC (capital punishment) only.*				
23	How many initial encounters did your Master's level therapist have this month? *Count only new encounters..*				
24	How many follow-up encounters did your Master's level therapist have this month? *Count only regularly scheduled follow-up visits.*				

Attachment D
IS11-04.3
Mental Health - Health Services Report Data Survey

25	How many individual encounters did your Master's level therapist have this month? *Count individual therapy sessions that are not crisis-oriented and were not scheduled to follow-up a particular issue or event. Represents ongoing individual therapy.*				
26	How many group encounters did your Master's level therapist have this month? *Count every patient who attended a group. For ongoing groups patients will be counted each time they attend a session.*				
27	How many initial treatment plans did your Master's level therapist complete this month? *Count both those initiated at the Reception centers and those initiated after a first mental health problem has been identified.*				
28	How many revised treatment plans did your Master's level therapist complete this month? *Count both those initiated at the Reception centers and those initiated after a first mental health problem has been identified.*				
29	How many Chronic Care Clinic visits did your Master's level therapist do this month? *Count only those visits where the patient is being admitted to or has been admitted to Chronic Care that are scheduled within the context of the Chronic Care pathways.*				
30	How many crisis intervention visits did your Master's level therapist do this month? *Count only unscheduled visits when the patient was seen on an urgent or emergent basis.*				
31	How many segregation rounds did your Master's level therapist complete this month? *Count the total number of offenders seen each time rounds were made.*				
32	How many suicide interventions did your Master's level therapist have this month? *Count each visit for every offender initiated on or seen while on suicide watch.*				
33	How many 30 day segregation treatment plans did your Master's level therapist complete this month?				
34	How many 90 day segregation treatment plans did your Master's level therapist complete this month?				
35	How many total (unduplicated) patients did your Master's level therapist see this month? (Do not include Group Therapy.) *Each different offender seen is only counted once.*				
36	How many intake batteries did your psychometrist administer this month? *Reception centers only.*				
37	How many intake encounters did your licensed psychologist have this month? *Reception centers and PCC only.*				
38	How many initial encounters did your licensed psychologist have this month? *Count only new encounters.*				
39	How many follow-up encounters did your licensed psychologist have this month? *Count only regularly scheduled follow-up visits.*				
40	How many individual encounters did your licensed psychologist have this month? *Count individual therapy sessions that are not crisis-oriented and were not scheduled to follow-up a particular issue or event. Represents ongoing individual therapy.*				
41	How many group encounters did your licensed psychologist have this month? *Count every patient who attended a group session. For ongoing groups patients will be counted every time they attend a session.*				
42	How many initial treatment plans did your licensed psychologist complete this month? *Count both those initiated at the Reception centers and those initiated after a first mental health problem has been identified.*				

Attachment D
IS11-04.3
Mental Health - Health Services Report Data Survey

43	How many revised treatment plans did your licensed psychologist complete this month? *Count both those initiated at the Reception centers and those initiated after a first mental health problem has been identified.*				
44	How many Chronic Care Clinic visits did your licensed psychologist do this month? *Count only those visits where the patient is being admitted to or has been admitted to Chronic Care that are scheduled within the context of the Chronic Care pathways.*				
45	How many crisis intervention visits did your licensed psychologist do this month? *Count only unscheduled visits when the patient was seen on an urgent or emergent basis.*				
46	How many segregation rounds did your licensed psychologist complete this month? *Count the total number of offenders seen each time rounds were made.*				
47	How many suicide interventions did your licensed psychologist have this month? *Count each visit for every offender initiated on or seen while on suicide watch.*				
48	How many 30 day segregation treatment plans did your licensed psychologist complete this month?				
49	How many 90 day segregation treatment plans did your licensed psychologist complete this month?				
50	How many total (unduplicated) patients did your licensed psychologist see this month? (Do not include Group Therapy.) *Each different offender seen is only counted once.*				
51	On average, how many days elapsed between a request for mental health services and the services actually being rendered? *Count the days between the date the request was actually received in mental health and the date the patient was actually seen.*				
52	On average, how many days elapsed between the time a mental health staff person referred a patient to the psychiatrist and the psychiatrist seeing the patient? *Count the days between the time the patient was seen by a mental health staff member and the date the patient was actually seen by the psychiatrist.*				
53	How many IRRs did your mental health staff respond to this month?				
54	How many Grievances did mental health staff respond to this month?				
55	How many Biggs admissions did your facility have this month? *Count each admission, including multiple admissions for a single patient.*				
56	How many Biggs discharges did your facility receive this month? *Count each discharge, including multiple discharges for a single patient.*				
57	How many CTC admissions did your facility have this month? *Count each admission, including multiple admissions for a single patient*				
58	How many CTC discharges did your facility receive this month? *Count each discharge, including multiple discharges for a single patient.*				
59	How many SRU admissions did your facility have this month? *Count each admission, including multiple admissions for a single patient*				
60	How many SRU discharges did your facility receive this month? *Count each discharge, including multiple discharges for a single patient.*				
61	How many WSRU admissions did your facility have this month? *Count each admission, including multiple admissions for a single patient*				
62	How many WSRU discharges did your facility receive this month? *Count each discharge, including multiple discharges for a single patient.*				
63	How many capital punishment offenders were admitted to PCC this month?				

Attachment D
IS11-04.3
Mental Health - Health Services Report Data Survey

64	How many SNU admissions did your facility have this month? *Count each admission, including multiple admissions for a single patient*				
65	How many SNU discharges did your facility receive this month? *Count each discharge, including multiple discharges for a single patient.*				
66	How many completed suicides did your facility have this month?				
67	How many SR-1 suicide attempts did your facility have this month?				
68	How many SR-2 suicide attempts did your facility have this month?				
69	How many SR-3 suicide attempts did your facility have this month?				
70	How many MH-3 offenders are on segregation status at your facility? *Count those MH-3 offenders in segregation on the last day of the month.*				
71	How many MH-4 offenders are on segregation status at your facility? *Count those MH-3 offenders in segregation on the last day of the month.*				
72	How many SR-3 offenders are at your facility as of the last day of the month?				
73	How many offenders in your facility are on medication?				
74	How many offenders in your facility are on psychotropic medication?				
75	% of total population on psych meds				
76	% of offenders on medication that are on psych meds				
77	How many offenders in your facility participated in some form of group therapy? *Count each offender only once no matter how many different groups or sessions he/she attended.*				
78	How many episodes of forced medications occurred in your facility this month? *Count each event, even if an offender received forced medications more than once.*				
79	How many of your offenders are on involuntary medications? *Count those offenders on the last day of the month who are on ongoing involuntary medication after a hearing or because of a court order.*				
80	How many suicide watches were initiated this month at your facility? *Count only initial suicide watch, not modifications. Count each watch initiated even if an offender incurred multiple watches.*				
81	How many Cose Observations were initiated this month at your facility? *Count only initial Close Observation, not modifications. Count each watch initiated even if an offender incurred multiple watches.*				
82	How many MMPIs were administered at your facility this month?				
83	How many Wechslers were administered at your facility this month?				
84	How many other IQ tests were administered at your facility this month?				
85	How many other tests were administered at your facility this month?				
86	How many unduplicated MH1 & MH2 offenders were seen this month?				
87	How many unduplicated MH3 offenders were seen this month?				
88	How many unduplicated MH4 offenders were seen this month?				
89	How many unduplicated MH5 offenders were seen this month?				

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-04.2 Staff Meetings Effective Date: August 13, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. Purpose: This procedure has been developed to insure monthly communications among all health care staff to include all health care professionals, administrative and support staff to identify health services concerns, administrative issues, and enhance the sharing of information.

A. **AUTHORITY:** 217.175, 217.320 RSMo, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. DEFINITION:

A. **Health Service Staff:** Includes all qualified health care professionals as well as administrative and support staff.

III. PROCEDURES:

A. Staff meetings will be chaired by the health services administrator and attended by all health services staff.

1. The meeting should be conducted at least monthly so that all health service staff have appropriate input on operational issues.

B. The health services administrator is responsible for:

1. developing an agenda and sending out notice of the meeting,

2. assuring minutes are prepared, the sign-in sheet is maintained, and attendance is documented,
3. maintaining an original copy of the minutes on file.

C. The agenda of the staff meeting should include the following topics:

1. announcements
2. old business
3. review of new/revised policy and procedure
4. new business
5. adjournment

D. Minutes of the meeting should be developed to provide information on the topics discussed.

1. the health services administrator should approve the minutes,
2. copies of the minutes should be distributed to;

   a. the department contract monitoring team,
   b. posted and/or distributed for all health service staff to review with signature of reviewer

3. the original should be maintained on file in the medical unit.

IV. ATTACHMENTS

None

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-A-04, Administrative Meetings and Reports - *essential.*

VI. HISTORY: This procedure was originally covered by IS11-3.2 Staff Meetings Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date: August 13, 2004

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-4.1 Medical Audit Committee (MAC) Effective Date: August 13, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. Purpose: This procedure has been developed to provide guidelines to ensure on-going communication and cooperative efforts between institutional and health service professionals.

A. **AUTHORITY:** 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. DEFINITION:

A. **Department of Corrections Monitoring Team:** Department of corrections staff members appointed by the division director of offender rehabilitative services to monitor healthcare services provided by the contracted provider.

B. **Guests:** For the purpose of this procedure guests may include other health organizations or correctional professionals.

III. PROCEDURES:

A. Medical audit committee (MAC) meetings will be chaired by the medical director or health services administrator.

1. Meetings should be held monthly to facilitate discussion of contracted health care administrative issues.

2. The health services administrator is responsible for:

a. developing an agenda and sending out notices of meetings,
b. providing statistical reports,
c. assuring all members have reports prepared for the meeting,
d. assuring minutes are distributed to the superintendent/designee, medical director, chief of custody, senior regional vice president/designee, and file.

B. The senior regional vice president, regional medical director and the department contract monitoring team will be ex-officio members. Members will include the superintendent/designee, institutional chief of mental health services, dentist and other institution staff determined appropriate by the superintendent and health services administrator.

C. Guests may be invited to attend the medical audit committee meeting at the invitation of the medical director, health services administrator or the superintendent/designee.

D. The meeting should be established on a mutually agreeable day and time, for example; the third Wednesday of every month at 2:00 p.m. in the training room.

E. The agenda should be forwarded to all members the week before the scheduled meeting.

F. Statistical reports should be provided at each medical audit committee meeting. The reports should include, but not be limited to the number of offenders receiving medical, dental, and mental health services by category of care, such as:

1. the number of offenders receiving health services by category of care,
2. referrals to specialists,
3. death,
4. infectious disease monitoring (e.g., hepatitis, HIV, STDs, TB);
5. emergency services provided to patients,
6. dental procedures performed,
7. mental health encounters by service, admissions to Biggs, group activities,
8. continuous quality improvement program; and
9. medication utilization.

G. The agenda of the medical audit committee meeting should be as follows:

1. Call to order

    a. acknowledgement of guests
    b. approval of previous meeting minutes

2. Old Business

    a. Health care activities

        1. health services report
        2. off-site utilization hospital/specialist
        3. offender grievance/s
        4. department reports
        5. infection control/safety
        6. environmental inspection reports

    b. policies and procedures
    c. continuous quality improvement
    d. in-services/training

3. strategic/operational plan update

4. new business

5. open discussion

6. adjournment

H. Minutes are to be prepared, approved and signed by the medical director, health services administrator and distributed to;

1. medical audit committee attendees
2. senior regional vice president/designee
3. department contract monitoring team/designee and
4. the original will by retained in the health services unit.

IV. ATTACHMENTS

None

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003. P-A-04, Administrative Meetings and Reports – *essential.*
B. IS11-4.3 Health Services Report-Prisons

VI. HISTORY: This procedure was originally covered by IS11-3.1 Medical Audit Committee (MAC) Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994
B. Revised Effective Date: October 15, 1999
C. Revised Effective Date: **August 13, 2004**

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-03 Medical Autonomy

Effective: August 13, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. Purpose: This procedure has been developed to ensure appropriate and timely medical, mental health and dental services are provided in an environment that encourages mutual trust and cooperation and conforms to the security regulations of the institution and the security requirements of the offender.

A. **AUTHORITY:** 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. DEFINITION:

A. **Autonomy:** The quality of having the ability to function independently.

B. **Health Service Staff:** Includes all qualified health care professionals as well as administrative and support staff.

C. **Institutional Custody Staff:** Includes custody officer I, custody officer II, custody officer III, custody supervisor I, and custody supervisor II.

D. **On-Call Service:** Availability of a licensed practitioner; Physician, Psychiatrist, or Dentist by means of telephone or in person to confer regarding a patient's health status.

E. **Responsible Dentist:** Supervises clinical judgments regarding the dental care provided to offenders at a specific facility. This includes establishing and implementing procedures for clinical aspects of the program; monitoring the appropriateness, timeliness and responsiveness of dental care and treatment; and reviewing the recommendations for treatment of offenders made by healthcare providers in the community.

F. **Responsible Physician:** Supervises clinical judgments regarding the care provided to offenders at a specific facility. This includes establishing and implementing procedures for clinical aspects of the program; monitoring the appropriateness, timeliness and responsiveness of care and treatment; and reviewing the recommendations for treatment of offenders made by health care providers in the community.

G. **Responsible Psychiatrist:** Supervises clinical judgments regarding the mental health care provided to offenders at a specific facility. This includes establishing and implementing procedures for clinical aspects of the program; monitoring the appropriateness, timeliness and responsiveness of care and treatment; and reviewing the recommendations for treatment of offenders made by mental health providers in the community.

III. PROCEDURES:

A. The medical director and/or regional medical director shall serve as the responsible physician.

B. The psychiatrist and/or director of psychiatry shall serve as the responsible psychiatrist.

C. The dentist and/or director of dental services shall serve as the responsible dentist.

D. The health services administrator shall serve as the administrative health authority for the institution.

E. The medical director will provide overall supervision for clinical services on-site and serve as liaison for clinical matters with medical providers outside the system.

F. The regional medical director and director of psychiatry will provide for clinical on-call service of their respective discipline.

G. The superintendent/designee shall provide administrative support to ensure the accessibility of health services to offenders and the physical resources deemed necessary for the delivery of health care (e.g., custody staff for movement and/or transportation).

H. Decisions on the types of treatment and need for transfer to outside resources shall be the responsibility of the medical director and/or regional medical director.

1. The medical director shall work in conjunction with the superintendent/designee in cases where security and control of the offender are issues.

I. Health service staff shall adhere to institutional security regulations and shall follow institutional services procedures, institutional standard operating procedures, and departmental procedures.

J. Any conflicts which may arise between medical autonomy and security requirements should be addressed and resolved between the health service administrator/designee, responsible physician and superintendent/designee at the institutional level and review though the continuous quality improvement program in accordance with IS11-06 Comprehensive-Continuous Quality Improvement Program.

IV. ATTACHMENTS

None

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003. P-A-03, Medical Autonomy – *essential.*

VI. HISTORY: This procedure was originally covered by IS11-2.1, Medical Autonomy Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A.	Original Effective Date:	August 15, 1994
B.	Revised Effective Date:	October 15, 1999
C.	Revised Effective Date:	August 13, 2004

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-02 Responsible Health Authority

Effective Date: **August 13, 2004**

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

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I. Purpose: This procedure has been developed to identify the authority responsible for the provision of health services to offenders of the Missouri Department of Corrections.

A. **AUTHORITY:** 217.175, 217.320 RSMo, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. DEFINITION:

A. **Director of Dental Services:** A contracted professional who serves as the responsible chief dentist for a specific region of dental services, overseeing all dentists providing dental services for the offender population; ensures the dental services provided comply with applicable Federal, State, and Local laws and regulations, as well as department contract requirements and National Commission on Correctional Health Care health related standards.

B. **Director of Mental Health Services:** A contracted professional who serves as the regional mental health administrative authority responsible for the delivery of contract services.

C. **Director of Nursing:** A contracted professional who serves as the responsible director of nursing services for an assigned facility or region, (site/facility operations) , overseeing all nursing operations for the offender population; ensures the nursing services provided comply with applicable Federal, State, and Local laws and regulations, as well as department contract requirements and National Commission on Correctional Health Care health related standards.

D. **Director of Psychiatry:** A contracted professional who serves as the responsible psychiatrist for a specific region or department, overseeing all psychiatrists providing mental health care for the offender population; ensures mental health services provided comply with applicable federal, state, local laws and regulations, as well as department

contract requirements and National Commission on Correctional Health Care mental health related standards.

E. **Director of Sex Offender Services:** A contracted or department of corrections professional who serves as the Missouri sexual offender program/sexual offender assessment unit authority responsible for the delivery of contract services consulting with facility administrative staff concerning pragmatic aspects.

F. **Health Services Administrator:** A contracted professional who serves as the site medical health administrative authority responsible for the delivery of contract services at an assigned institution.

G. **Infection Control Coordinator:** A contracted professional who serves as the responsible coordinator of infection control services for a specific region overseeing infection control issues for the offender population; ensures the infection control services provided comply with applicable Federal, State, and Local laws and regulations, as well as department contract requirements, Center for Disease Control and Prevention, Missouri Department of Health, and National Commission on Correctional Health Care health related standards.

H. **Information Systems Specialist:** A contracted professional who serves as the regional information systems authority responsible for a specific region overseeing information systems related to computerized medical records of contract services.

I. **Institutional Chief of Mental Health Services:** A contracted or department of corrections professional who serves as the site mental health authority responsible for the delivery of contract services at an assigned institution.

J. **Medical Director:** A contracted professional who serves as the site responsible physician of an assigned institution.

K. **Pharmacy Director:** A contracted professional who serves as the responsible pharmacist for a specific region or department, overseeing all pharmaceutical operations for the offender population; ensures the pharmacy services provided comply with applicable Federal, State, and Local laws and regulations, as well as department contract requirements and National Commission on Correctional Health Care related standards.

L. **Quality Assurance Coordinator:** A contracted professional who serves as the responsible coordinator of services for specific region overseeing a comprehensive continuous quality improvement program of a multidisciplinary quality improvement that measures processes and outcomes to effect remedial actions or strategies.

M. **Regional Medical Director:** A contracted professional who serves as the responsible physician for a specific region or department, overseeing all physicians providing health care for the offender population; ensures the health services provided comply with applicable federal, state, local laws and regulations, as well as department contract requirements and National Commission on Correctional Health Care related standards.

N. **Senior Regional Vice President:** A contracted professional who serves as the administrative health authority for a specific region or department; is responsible for the delivery of contract services in all institutions under contracted health services of the department.

III. PROCEDURES:

A. Correctional Medical Services (CMS) regional reporting is as outlined on the CMS organizational chart (Attachment-A).

B. The health services administrator shall be the administrative health authority for the facility.

C. The facility medical director will be the authority for clinical judgments at the facility.

D. The responsible psychiatrist shall be the final authority for clinical psychiatric determinations at the facility.

E. The institutional chief of mental health for each institution shall be the site mental health authority for their assigned institution.

F. The regional medical director will be the final clinical authority for necessary medical clinical determinations.

G. The director of dental services will be the final clinical authority for necessary clinical dental determinations.

H. The director of psychiatry will be the final clinical authority for clinical mental health determinations.

I. The senior regional vice president/designee will be the final administrative authority for provision of health services.

IV. ATTACHMENTS

A. CMS Organizational Chart

B. MODOC DORS Organization Chart

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003. P-A-02, Responsible Health Authority – *essential.*

VI. HISTORY: This procedure was originally covered by IS11-1.1 Responsible Health Authority Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

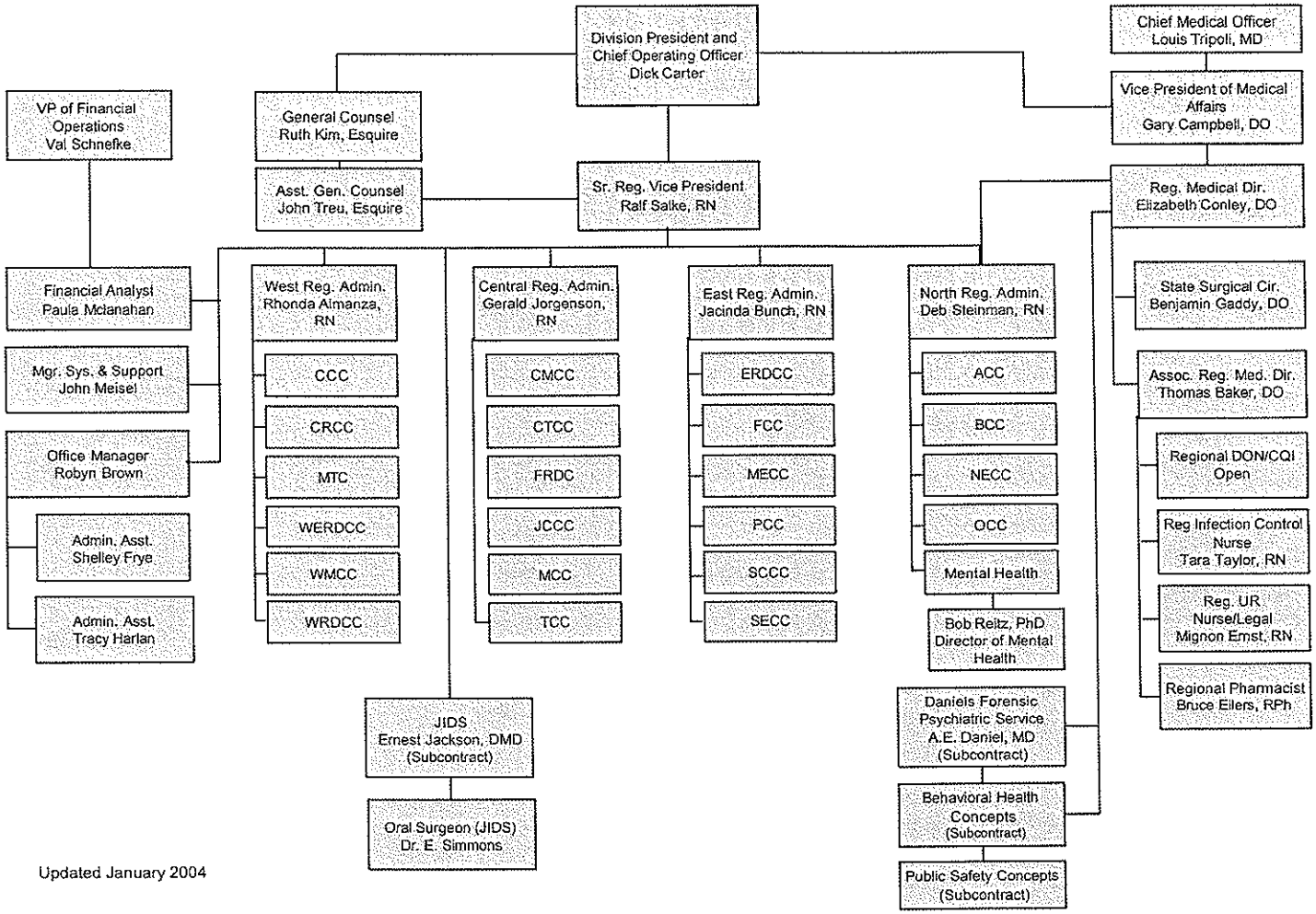
A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date: August 13, 2004

Attachment A

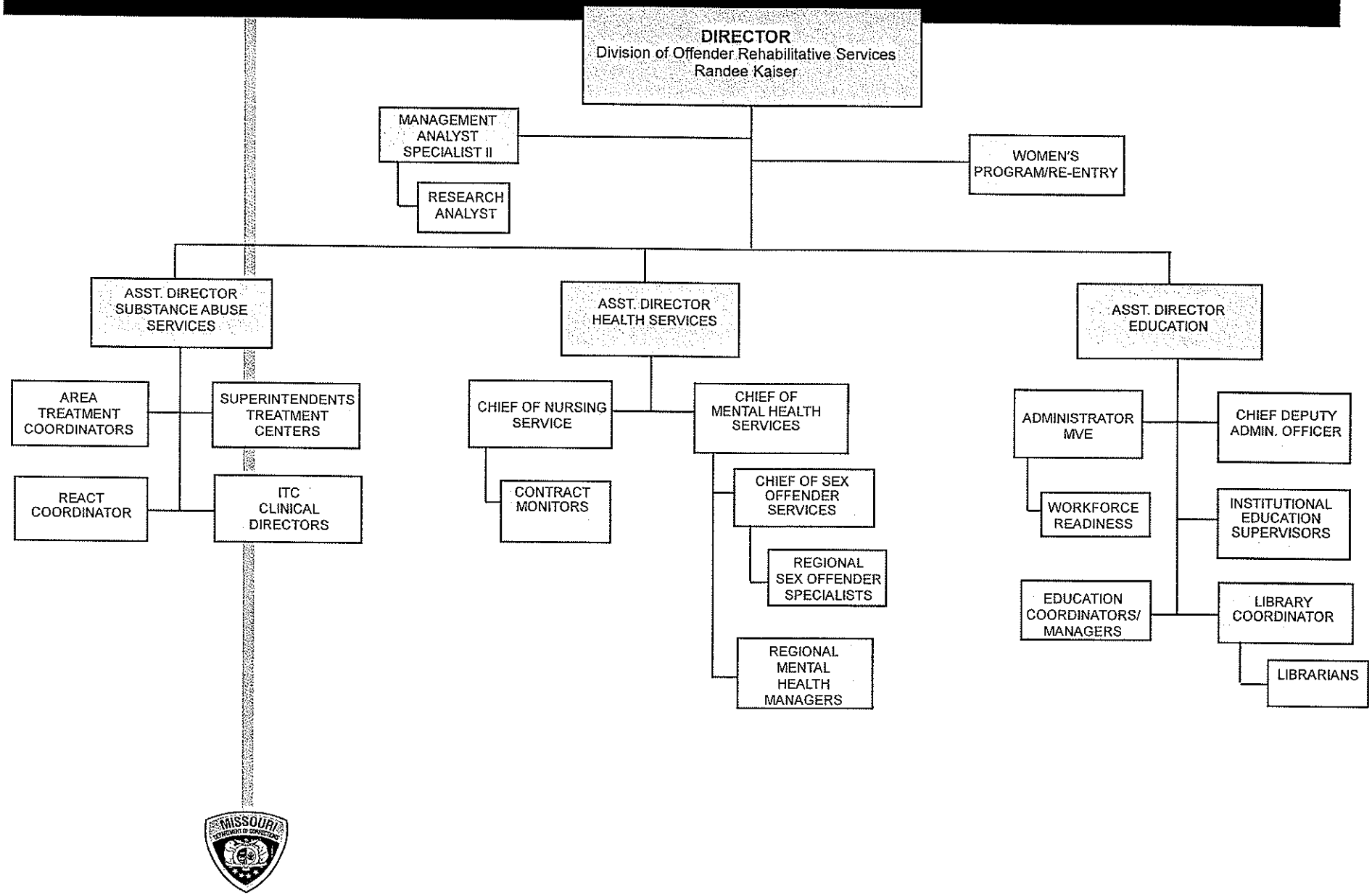
Correctional Medical Services, Inc. - Missouri Region Organizational Chart



Updated January 2004

Attachment B

Missouri Department of Corrections
Division of Offender Rehabilitative Services



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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-09 Privacy of Care Effective Date: October 22, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

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I. **Purpose:** This procedure provides guidelines to provide all offender patient clinical encounters with privacy consistent with security needs and encourage the patient's subsequent use of health services.

A. **AUTHORITY:** 217.175, 217.320 RSMo, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Clinical encounters:** Interactions between offenders and health care providers that involve a treatment and/or exchange of confidential information.

III. **PROCEDURES:**

A. All health care services, including the gathering of history information, should be conducted in an area private enough to enable the offender to feel free to discuss problems.

1. Custody staff should be available in the immediate vicinity when security considerations require such.

2. Every effort should be made to provide either auditory or visual privacy.

3. If determined to be a security risk, the officer should not leave the offender unattended.

B. Whenever possible, a private treatment room should be used for health services.

C. Verbal consent should be obtained from an offender requiring a pelvic or rectal exam as stated in procedure IS11-70 Informed Consent.

D. A health care or custody staff chaperone of the same sex as the offender should be present for personal body area exams (e.g., pelvic exam by male physician).

E. When effective communication during the clinical encounter is compromised by deficits in speech, hearing, or language barriers, an interpreter or other assistive device should be made available. Consideration should be given for the patient's preference and desire for privacy.

F. Health staff encounters in segregation areas should take additional precautions to ensure privacy of care as outline in IS11-45 Health Evaluation of Offenders in Administrative Segregation and Protective Custody and IS11-39 Health Evaluation of Offenders in Disciplinary Segregation.

G. Custody staff that may have the opportunity to over hear portions of health encounters due to security issues shall be instructed on the importance of maintaining patient confidentiality/offender privacy.

1. Instructions regarding privacy of care should be included during basic security and institutional core training.

IV. ATTACHMENTS

None

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003. P-A-09 Privacy of Care - *important*.
B. IS11-20 Training for Correctional Officers
C. IS11-39 Health Evaluation of Offenders in Disciplinary Segregation
D. IS11-45 Health Evaluation of Offenders in Administrative Segregation and Protective Custody
E. IS11-70 Informed Consent

VI. HISTORY:

This procedure was originally covered by IS11-6.1 Privacy of Care Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994,

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date: